Provider Manual

Molina Healthcare of New Mexico, Inc. (Molina Healthcare or Molina)

Turquoise Care

2025

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Provider Agreement with Molina Healthcare. “Molina Healthcare” or “Molina” has the same meaning as “Health Plan” in your Provider Agreement with Molina. The Provider Manual is customarily updated annually but may be updated as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated: June 2025

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1. BACKGROUND AND OVERVIEW OF MOLINA OF HEALTHCARE OF NEW MEXICO, INC.

Introduction to Turquoise Care

This Provider Manual serves as a guide for providing covered services to Molina Members enrolled in Turquoise Care. The cornerstone of this program is a comprehensive network, delivering medical, behavioral, and long-term support services (LTSS), emphasizing Member care coordination. This ensures that Members receive the right care, in the right place, at the right time, ensuring better health outcomes. Quality care and improved health outcomes are determined by:

1. Assessing each Member's physical, behavioral, functional, and psychosocial needs
2. Identifying the medical, behavioral, or LTSS Provider
3. Ensuring timely access to care, and provision, coordination, and monitoring of services necessary to help each Member maintain or improve physical and/or behavioral health status
4. Facilitating Member access to other social support services, and assistance needed to promote Members health, safety, and welfare

All contracted Practitioners or organizational Providers will be notified of any additional updates or changes that occur via the Provider Newsletter or by letter. To receive a printed version of the Molina Provider Manual, please contact your Provider Contact Center toll-free at (855) 322-4078.

Network Management and Operations Department

The Network Management and Operations Department (NM&O) is devoted exclusively to the needs of contracted Providers.

- **Provider Contracting**
  The staff in this area builds the contracted network by negotiating agreements with Practitioners and organizational Providers primarily in New Mexico, bordering states, and nationwide. Contracting works with Providers to help them understand both their contract language terms and reimbursement fee schedules. They may also amend agreements as needed due to regulatory or program requirements. This department also provides geo-access analysis reporting to ensure Members have access to an adequate network of Providers of all specialties.
- **Provider Relations**
  This area has dedicated Provider Relations Representatives (PRRs) to conduct visits to Provider offices, provide training, answer questions, and serve as the plan point of contact for all Provider needs. The PRR Territory Map depicts the plan service areas and the PRR responsible for each geographic area. The contact information for individual PRRs may be found in the **Contact Information** section of this Provider Manual.

- **Provider Credentialing & Delegation**
  The Credentialing and Delegation departments' primary responsibility is to meet the National Committee on Quality Assurance (NCQA) quality metrics in credentialing or delegating plan functions. The departments oversee the collection of practitioner and facility credentialing documents, ensure quality assessments of Providers, perform ongoing monitoring of network Providers, and conduct the Credentialing Committee. The Delegation department ensures that Molina's delegated Providers are compliant with regulatory requirements by auditing the delegates periodically and assessing their performance relative to NCQA and Molina's quality standards.
- **Provider Network Administration (PNA**)
  The PNA department ensures that Provider data collected from all areas of the health plan is entered accurately into Molina's Provider database. This data can range from the data entry of a Provider's practice address to the complex configuration of Provider contract reimbursement. PNA also oversees the Molina Provider Directory data and ensures its accuracy.

2. CONTACT INFORMATION

Provider Relations

The Molina Provider Contact Center handles telephone inquiries from Providers regarding claims, appeals, authorizations, eligibility, and general concerns. Molina Provider Contact Center representatives are available at (855) 322-4078 from 8 a.m. to 5 p.m., MT, Monday through Friday, excluding state and federal holidays. Hearing Impaired (TTY/TDD): 711.
Molina strongly encourages Participating Providers to submit claims electronically via a clearinghouse or the Availity Essentials (Availity) portal whenever possible.
EDI Payer ID Number: 09824
To verify the status of your claims please use the Availity portal. Claim questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity portal, or by contacting the Molina Provider Contact Center.
Eligibility verifications can be conducted at your convenience via the Eligibility and Benefits module on the Availity portal.
Availity portal: provider.molinahealthcare.com

Provider Relations

The Provider Relations department manages Provider calls regarding issue resolution, Provider education and training. The department has Provider Relations Representatives who serve all of Molina's Provider network. To reach your dedicated Provider Relations Representative, please visit New Mexico Providers Home.

Member Services

The Molina Member Services Contact Center handles all telephone inquiries regarding benefits, eligibility/identification, pharmacy inquiries, selecting or changing primary care practitioner (PCPs), and Member grievances. Molina Member Services Contact Center representatives are available 8 a.m. to 5 p.m., MT, Monday through Friday, excluding state and federal holidays.
Toll-Free Phone: (844) 862-4543
TTY/TDD: 711 Relay

Member Appeals and Grievances

Services are available in English and Spanish.
Toll-Free Phone: (844) 862-4543
Fax: (505) 342-0583
TTY/TDD: 711 Relay
Email: MNM.Medicaid.MemberAppealsandGrievances@molinahealthcare.com

Claims Department

Molina strongly encourages participating Providers to submit claims electronically via a clearinghouse or the Availity portal whenever possible.

- Availity portal
- EDI Payer ID: 09824

To verify the status of claims, please use the Availity portal. Claim questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity portal or by contacting the Molina Provider Contact Center.

Claims Recovery

The Claims Recovery department manages recovery for overpayment and incorrect payment of claims.

Provider Disputes	Molina Healthcare of New Mexico PO Box 182273 Chattanooga, TN 37422
Refund Checks Lockbox	Molina Healthcare of New Mexico PO Box 741766 Los Angeles, CA 90074-1766
Toll-Free Phone	(866) 642-8999

Compliance and Fraud AlertLine

Suspected cases of fraud, waste, or abuse must be reported to Molina. You may do so by contacting the Molina AlertLine or by submitting an electronic complaint using the website listed below. For additional information on fraud, waste, and abuse, please refer to the **Compliance** section of this Provider Manual.
The Molina AlertLine is available 24 hours a day/7 days a week.
Address: Molina Healthcare of New Mexico, Inc.
P.O. Box 3887
Albuquerque, NM 87190
Toll-Free Phone: (866) 606-3889
Website: MolinaHealthcare.AlertLine.com

Care Coordination

Molina provides Care Coordination designed to assist Members and their families in better understanding their chronic health condition(s) and adopting healthy lifestyle behaviors. Molina's Care Coordination will be incorporated into the Member's treatment plan to address the Member's health care needs.
Toll-Free Phone: (855) 322-4078
Toll-Free Fax: (833) 558-6769 for complex, chronic conditions

Credentialing

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three (3) years or sooner, depending on Molina's credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network. For additional information about Molina's Credentialing program, please refer to the **Credentialing and Recredentialing** section of this Provider Manual.
Email: MHNMCredentialing@MolinaHealthcare.com
Toll-Free Phone: (855) 322-4078

24-Hour Nurse Advice Line

This telephone-based Nurse Advice Line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week.
Toll-Free Phone: (833) 965-1558
TTY/TDD: 711 Relay

Health Care Services

The Health Care Services (HCS) department delivers utilization management (UM) and care coordination (CC) services to Molina Members. UM conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. CC works with Members to address health-related issues, gaps in care, coordination of care, and education to Members and others. Participating Providers are required to interact with Molina's HCS department electronically whenever possible. Prior Authorizations/Service Requests and status checks can be easily managed electronically.

Managing Prior Authorizations/Service Requests electronically provides many benefits to Providers, such as:

- Easy to access 24/7 online submission and status checks
- Ensures Health Insurance Portability and Accountability Act (HIPAA) compliance
- Ability to receive real-time authorization status
- Ability to upload medical records
- Increased efficiencies through reduced telephonic interactions
- Reduces costs associated with fax and telephonic interactions

Molina offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Molina via the Availity portal. See Molina's Provider Portal Quick Reference Guide or contact your Provider Relations Representative for registration and submission guidance.

- Submit requests via 278 transactions. See the EDI transaction section of our website for guidance.

Authorizations & Inpatient Census	Availity portal: Provider.MolinaHealthcare.com
Physical Health	Phone: (855) 322-4078 Fax: (833) 558-6769
Radiology	Phone: (855) 714-2415 Fax: (877) 731-7218
NICU (Progeny Health)	Phone: (888) 832-2006 Fax: (866) 484-6087
Transplant	Phone: (855) 714-2415 Fax: (877) 813-1206
Pharmacy – Benefits, Medical Office Drugs, I.V. Infusion, TPN	Phone: (855) 322-4078 Fax: (877) 731-7218

Health Management

Molina provides health management programs designed to assist Members and their families to better understand their chronic health condition(s) and adopt healthy lifestyle behaviors. The programs include:

- Molina My Health – Tobacco Cessation Program
- Molina My Health – Weight Management Program
- Molina My Health – Nutrition Consult Program

Toll-Free Phone: (833) 269-7830
Toll-Free Fax: (800) 642-3691

Behavioral Health

Molina manages all components of covered services for behavioral health. For Member behavioral health needs, please contact Molina Member Services for assistance. Molina has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services telephone number on the back of their Molina Member ID card. For additional information please refer to the **Behavioral Services** section of this Provider Manual.
Toll-Free Phone: (844) 862-4543

Pharmacy

The prescription drug benefit is administered through CVS. The drug formulary and a list of in-network pharmacies are available on the MolinaHealthcare.com website or by contacting Molina at (855) 322-4078. For additional information please refer to the **Pharmacy** section of this Provider Manual.

Quality

Molina maintains a Quality department to work with Members and Providers in administering the Molina Quality Improvement (QI) Program. For additional information please refer to the **Quality** section of this Provider Manual.
Toll-Free Phone: (855) 322-4078

Dental

DentaQuest: Toll-Free Phone: (800) 341-8478

Vision

March Vision: Toll-Free Phone: (844) 706-2724

Transportation

Superior Medical Transportation: Toll-Free Phone: (833) 707-7100

Availity Essentials Portal

Providers and third-party billers can use the no-cost Availity portal to perform many functions online without the need to call or fax Molina. Registration can be performed online, and once completed, the easy-to-use tool offers the following features:

- Verify and print Member eligibility, covered services and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps)
- Claims
  - Submit Professional (CMS-1500) and Institutional (CMSA-21450 [UB04]) claims with attached files
  - Correct/void claims
  - Add attachments to previously submitted claims
  - Check claim status
  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
  - Create and manage claim templates
  - Create and submit a claim appeal with attached files
- Prior Authorization/Service Requests
  - Create and submit Prior Authorization/Service Requests
  - Check status of Prior Authorization/Service Requests
- Download forms and documents
- Send/receive secure messages to/from Molina
- Access Member care plans

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Register today to access our online services. A video will guide you through the easy online registration process at Provider Portal – Provider Self-Serve.

Molina Website

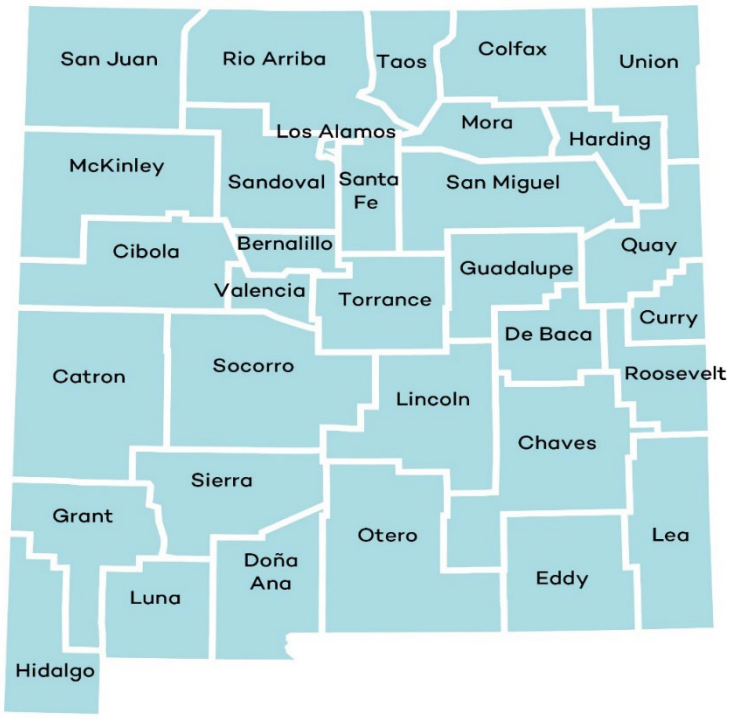
Molina's website provides information, materials, news, updates, and more.

Visit our website at MolinaHealthcare.com to access the following information:

1. Provider manual
2. Provider forms
3. Provider policies
4. HIPAA Resource Center
5. Electronic Data Interchange (EDI), Electronic Fund Transfer/Remittance Advice (EFT/ERA) Information
6. Drug list
7. Health resources
8. Provider newsletters
9. Provider communications
10. Contact information
11. Clinical Practice Guidelines
12. HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Scores
13. Provider coding tools
14. Disease Management/Health Management Programs
15. Preventive Health Guidelines
16. Critical Incident Reporting

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Molina Service Area


San Juan
Rio Arriba
Taos
Colfax
Union
Los Alamos
Mora
Harding
McKinley
Sandoval
Santa Fe
San Miguel
Cibola
Bernalillo
Quay
Guadalupe
Valencia
Torrance
Curry
De Baca
Catron
Socorro
Roosevelt
Lincoln
Chaves
Sierra
Grant
Otero
Lea
Doña Ana
Eddy
Luna
Hidalgo

3. PROVIDER RESPONSIBILITIES/PARTICIPATION REQUIREMENTS

Prior to contracting with Molina, Providers must be enrolled with New Mexico Medicaid.

All Providers with a National Provider Identifier (NPI) that are not associated with an active New Mexico Medicaid Fee-For-Service or Managed Care Provider record (status 60 or 70) in the Omnicaid system and have or will provide health care services are required to enroll with the New Mexico Medical Assistance Division (MAD) Medicaid Program.

Joining a Practice

Any Practitioner changes (i.e., joining or leaving a practice) must be communicated to the appropriate Molina Provider Relations Representative and should be initiated at least 30 days prior to the actual date of the change.

New Molina Provider

1. Complete a Provider Information Form (PIF) located on our Provider Website at MolinaHealthcare.com.
2. Complete the New Mexico Disclosure Form – this must be completed and submitted with the PIF located on our Provider Website at MolinaHealthcare.com.
    - Provide up-to-date Council for Affordable Quality Healthcare, Inc., (CAQH) information on the PIF or complete a Credentialing Application
    - Send via email to MHNMCredentialing@Molinahealthcare.com.
    - Upon receipt of a clean application, Providers will be credentialed within 30 calendar days and loaded within 15 calendar days.

Existing Molina Provider

1. Notify your designated Provider Relations Representative of the change in practice within 30 days of the change. If notification is not received within 30 days, new credentialing must be completed (follow the above steps as a new Provider).
2. If joining an existing contracted Provider, notification must be sent to Molina within 30 days.
3. If a new practice is opened, notification must be sent within 30 days. Complete the New Mexico Disclosure Form and a W-9. If you are a PCP, OB/GYN, or high-volume Behavioral Health Provider, a site visit may be required.

Leaving a Practice/Provider Termination

All Molina contracted Practitioners/Providers and/or Provider groups must notify Molina and their Molina patients of termination of an individual Provider or the entire group 30 days prior to the effective date of termination. When terminating a Contracted Provider with Molina, the

Provider must notify the Provider Relations Representative in writing or send a notification to MHNM.ProviderServices@MolinaHealthcare.com.

The Provider Relations Representative will remove the terminating Provider from various databases (including those that affect the production of an online or printed directory) and claims processing system. Molina's Enrollment department will notify Members of PCP change. A Member assigned to a terminated PCP will be given adequate time to select a new PCP. If a new PCP is not selected, one will be assigned to them from a list of participating PCPs in their geographic area that is accepting new patients.

On-Call Arrangements

Molina contracted Providers must use Practitioners contracted with Molina for on-call arrangements. Practitioners must contact Molina and obtain prior authorization if a non-contracted Practitioner is needed for on-call.

Primary Care Practitioner (PCP) Responsibilities

The Turquoise Care PCP is a medical or behavioral health Practitioner responsible for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of the Member's care.

1. The PCP provides all the Member's primary care health services. PCPs are responsible for 24-hour, seven (7) day-a-week coverage. Members are instructed to contact their PCP prior to seeking care in all cases except life-threatening emergencies. Members who require care for a life-threatening emergency are instructed to notify their PCP within 24 hours of emergency treatment. A family member may make this notification. If electronic answering machines are used, messages should include the following: 1) Name and telephone number of the on-call Practitioner, with instructions to contact that Practitioner; and 2) A disclaimer that if the Member presents to the emergency room or urgent care facility without contacting the on-call Practitioner, payment by Molina can be denied.
2. When specialized care is needed, the PCP will provide a referral to a participating specialist. The PCP should ensure the information from the specialty Practitioner is reviewed and included in the Member's medical record within 90 days after the conclusion of treatment. If the Member requires care that can only be provided outside of Molina's Provider panel, the PCP will work with Molina and/or Medical Director to arrange for the appropriate services.
3. Upon request, the PCP is required to provide the Member information about the PCP's education, training, applicable certification, and any subspecialty.
4. All lab and imaging services ordered by the PCP must be performed either in the PCP's office, the office of Molina's preferred/participating Practitioner/Provider or laboratory, or at one of the participating hospitals or outpatient centers.
5. All elective hospital inpatient, residential treatment, skilled nursing facility, and home health care admissions must be approved in advance by the PCP or the admitting

Practitioner (if the PCP has made a referral). The PCP or admitting Practitioner must coordinate care with hospitals that require in-house staff to examine or treat Members. The PCP, specialist and hospitalist caring for a Member with special health care needs should contact Molina to assist in coordinating care with the assigned Care Coordinator.

6. The PCP should refer the Member to outpatient surgical services whenever medically appropriate.
7. The PCP should advise the Member of advance directive processes available. The Member can obtain forms by calling the Molina Member Service Department.
8. The PCP maintains Members' medical records in accordance with the standards established by Molina that are outlined in this section.
9. The PCP is responsible for educating and training all individuals working with their medical practice to assure that the procedures for Molina's managed care delivery system are followed correctly. Representatives of the Provider Relations department are available to provide staff training which may include referral, grievance, and billing procedures.

PCPs, BH practitioners, and other Practitioners/Providers should play an active role in the Member's behavioral health treatment. One of the most important things to remember is that the Member and their family must be a part of the treatment planning process.

The role of the PCP is to refer the Member to the appropriate level of behavioral health care. Although a referral is not required for a Molina Member to access behavioral health care directly, the PCP should be available to assist the Member in accessing needed behavioral health services. The PCP will offer a member a referral for behavioral health services based on the following indicators:

1. Suicidal/homicidal ideation or behavior
2. At risk of hospitalization due to a behavioral health condition
3. Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility
4. Trauma victims
5. Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment or other developmental disabilities
6. Request by Member or Representative for behavioral health services
7. Clinical status that suggests the need for behavioral health services
8. Identified psychosocial stressors and precipitants
9. Treatment compliance complicated by behavioral characteristics
10. Behavioral and psychiatric factors influencing medical conditions
11. Victims or perpetrators of abuse and/or neglect and Members suspected of being subject to abuse and/or neglect
12. Non-medical management of substance abuse
13. Follow-up to medical detoxification
14. An initial PCP contact or routine physical exam indicates a substance abuse problem
15. A prenatal visit indicates substance abuse problems

16. Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse
17. A pattern of inappropriate use of medical, surgical, trauma, or emergency room services that could be related to substance abuse or other behavioral health conditions
18. The persistence of serious functional impairment

Molina defines an Emergency Medical Condition as a Physical Health or Behavioral Health condition manifesting itself through acute symptoms of sufficient severity (including nerve pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the Member's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Serious disfigurement to the Member.

PCP Role in an Emergency Situation

To assist in reducing the inappropriate use of emergency department (ED) facilities during normal business hours, PCPs MUST have a health professional available to triage patients under the following circumstances:

1. Patients who walk into a PCP's office should be evaluated in a reasonable time frame to determine the emergent nature of the condition, and treatment should be scheduled that corresponds to the immediacy of the situation.
2. Telephonic requests to the PCP's office by Members must be assessed to determine appropriate action.
3. Telephonic requests to the PCP's office from other Practitioners requesting approval to treat Members must be assessed for appropriate action.
4. The PCP must then advise the Member on a medically prudent course of action (i.e., whether to come to the office or to be referred for treatment to the emergency room (ER) at a participating hospital or urgent care center).

If the PCP is unavailable, Practitioner back-up as part of the triage system should be provided by a Practitioner with the same level or higher of training and specialty. PCPs are not required to submit referrals for patients they refer to an ER but are encouraged to direct Members to appropriate care.

Out-of-Area Emergencies

Coverage for out-of-area emergencies is provided only for true emergencies - those that could not have been anticipated. Routine medical services are not covered when provided outside the service area. Members are instructed to seek care at the nearest appropriate facility such as a clinic, urgent care center, or hospital ED.

When notified of an out-of-area emergency requiring follow-up or inpatient admission, the PCP is expected to monitor the Member's condition, arrange for appropriate care, and determine whether the Member can be safely transferred to a participating hospital.

Individualized Education Program (IEP) & PCP

The IEP is a written plan of care created for every child with a disability attending school. The IEP is a principal tenet of the Individuals with Disabilities Education Act (IDEA) that is developed, written and as appropriate, revised in accordance with the Act. It is the cornerstone for a special education student, ensuring their right to a free and appropriate education, including medically necessary services.

In addition to academic services, speech/language therapy, occupational therapy, physical therapy, social work, health services (i.e., medications, tube feedings), audiology and psychological services may be provided.
The PCP for the child must receive a copy of the child's IEP if Medicaid-reimbursable services are requested. The PCP must then sign off on the plan of care to ensure they are aware of the medically necessary services their patient is receiving at school.
The PCP must sign off on the IEP and return it to the designated contact in the school setting. Per IDEA, schools are required to provide medically necessary services. However, without the PCP's signature, the schools cannot bill for services rendered. There is ***no medical liability or financial loss to the PCP*** in approving these services.

For more information on IEPs or the Medicaid School-Based Services Program, please contact:

Medicaid School-Based Services Program Manager
Medical Assistance Division Benefits Bureau
Local in Santa Fe: (505) 827-6233
Medicaid School-Based Services Program Director
Medical Assistance Division Benefits Bureau
Local in Santa Fe: (505) 827-3199

Specialist as PCP

A Member may select a board-certified specialist as their PCP if clinically appropriate and if the specialist agrees to provide PCP services. Members are advised in the Member Handbook that, if appropriate, they may use a specialist as a PCP based on a special health care need. Board-certified physicians from appropriate specialty areas can function as PCPs. Board-certified psychiatrists are the only behavioral health Practitioners who qualify and may serve as PCPs.

Specialty Provider Responsibilities

When the PCP determines that a Molina Member needs to see a specialist, the PCP initiates a referral. Practitioners/Providers need to advise the PCP when follow-up care is necessary. The specialty Practitioner may treat as necessary within the parameters of the referral from the PCP

that is appropriate (i.e., lab tests, radiology, therapies, etc.). If the Member requires a procedure for which prior authorization is required, including hospitalization, the specialty practitioner is responsible for obtaining the proper authorization from Molina.
Specialty Practitioners will ensure that services provided are documented and sent to the Member's PCP within 90 days after the conclusion of each treatment. The specialty Practitioner will be responsible for educating and training all individuals working within their medical practice to ensure that Molina's procedures are followed correctly. Upon request, the specialty Practitioner is required to provide the Member with information about the specialty Practitioner's/Provider's education, training, applicable certification, and any subspecialty.
The specialty Practitioner will advise the Member of advance directive processes available. Members may obtain forms by calling the Molina Member Service Department.
Under certain circumstances, and with prior approval, a specialist can act as the Member's PCP for some chronic or long-term care conditions. Call the Molina Provider Contact Center for more information.

Critical Incident Reporting

Providers delivering Home and Community-Based Services (HCBS) are responsible for Incident Management. All Providers rendering Turquoise Care-funded services to the HCBS population are required to report critical incidents and to develop and implement an incident management system that, at a minimum, maintains, tracks, and trends report data and includes the data in quality assurance activities.
Community agencies providing HCBS are required to report critical incidents to the State of NM Health Care Authority (HCA) using their online Critical Incident Reporting portal at criticalincident.hsd.state.nm.us. HCBS include, but are not limited to, personal care services, self-directed benefit services, Behavioral Health (BH) services, and Home Health services.
All allegations of abuse, neglect, and exploitation of a Member must be reported, as well as any incidents involving emergency services, hospitalization, the death of a Member, the involvement of law enforcement, any environmental hazards that compromise the health and safety of a Member, and any elopement of missing Member.
Agencies that do not comply with the incident reporting requirements violate State statutes and Federal regulations and may be sanctioned up to and including termination of their Provider Agreement with Molina or by the HCA Medical Assistance Division.
Providers are expected to cooperate with any Molina Quality Improvement department investigation by providing additional information as requested. Request for additional information may include root cause analysis, documentation from internal investigations, policies and procedures, site visits, chart reviews and staff/Member interviews. Some investigations may be part of a collaboration with HCA Behavioral Health Collaborative, the New Mexico Department of Health, Child Protective Services, and Adult Protective Services.
For more information about critical incident reporting requirements or if you have questions regarding these requirements, please contact the Molina Provider Contact Center toll-free at (855) 322-4078.

Abuse and/or Neglect Reporting

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected in New Mexico must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are licensed physicians, residents or interns, law enforcement officers, judges presiding during a proceeding, nurses, schoolteachers, school officials, social workers, and clergy Members who have information not privileged as a matter of law.

1. **Child Abuse can be reported to** Children, Youth, and Family Department's (CYFD) statewide central intake child abuse hotline toll-free at (855) 333-SAFE [7233] or text SAFE from a cell phone, or to law enforcement or the appropriate tribal identity. Additional information regarding Child Protective Services can be found at Children Youth and Family Department Central Abuse Line.
2. **Adult Abuse can be reported to** the Adult Protective Services (APS) toll-free Hotline at (866) 654-3219 or at (505) 476-4912. Additional information regarding Adult Protective Services can be found on their website at aging.nm.gov/about/contact.

Advance Directives

Molina's policy is to ensure that all Members have access to information regarding the right to make informed decisions about their medical treatment, even when they can no longer speak for themselves. Advance Directive means written instructions (such as an Advance Health Directive, a Mental Health Advance Directive, a Psychiatric Advance Directive, a Living Will, a Durable Health Care Power of Attorney, or a Durable Mental Health Care Power of Attorney) recognized under State law relating to the provision of care when an individual is unable to make decisions for themselves.

Advance directives forms are State-specific to meet State regulations. For copies of forms applicable to New Mexico, please go to the Caring Connections website at caringinfo.org/planning/advance-directives/by-state/new-mexico/.

A mental health or psychiatric advanced directive (PAD) is a legal document designed to preserve the autonomy of an individual with mental illness during times when the mental illness temporarily compromises the individual's ability to make or communicate mental health treatment decisions.

The Mental Health Care Treatment Decision Act gives all individuals over the age of 18 the right to have a psychiatric advance directive and provides direction on the completion of a PAD and how organizations and Providers must utilize a PAD. The law includes a standard PAD form, which is optional. For more information on PADs in New Mexico and for a copy of the PAD form, link to: National Resource Center on Psychiatric Advance Directives.

All Practitioner/Provider office personnel with Member contact must maintain a general knowledge of this policy and the contents of the Advance Directives article text.

Non-discrimination of Health Care Service Delivery

Providers must comply with the nondiscrimination in health care service delivery requirements as outlined in the **Cultural Competency and Linguistic Services** section of this Provider Manual.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to the payment source. Specifically, Providers may not refuse to serve Molina Members because they receive assistance with cost sharing from a government-funded program.

Section 1557 Investigations

All Molina Providers shall disclose all investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act to Molina's Civil Rights Coordinator.
Molina Healthcare
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802
Toll-Free: (866) 606-3889
TTY/TDD: 711
Online: MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com
For additional information, please refer to the Department of Health and Human Services (HHS) website at federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, Equipment, Personnel and Administrative Servies

The Provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider Data Accuracy and Validation

Providers need to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Members and Provider network. Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as an NCQA-required element. Invalid information can negatively impact Member access to care, Member/PCP assignments, and referrals. Additionally, current information is critical for timely and accurate claim processing.

Providers must validate their Provider information on file with Molina at least once every 90 days for correctness and completeness.

Additionally, in accordance with the terms specified in your Provider Agreement with Molina, Providers must notify Molina of any changes as soon as possible, but at a minimum, 30 calendar days in advance of changes in any Provider information on file with Molina. Changes include, but are not limited to:

- Change in office location(s), office hours, phone, fax, or email
- Addition or closure of office location(s)
- Addition of a Provider (within an existing clinic/practice)
- Change in Provider or practice name, Tax ID and/or NPI
- Opening or closing your practice to new patients (PCPs only)
- Any other information that may impact Member access to care

For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement with Molina.

Please visit our Provider Online Directory at Molina Online Directory to validate your information. For corrections and updates, Providers can make updates through the CAQH portal, or you may submit a full roster that includes the required information above for each health care Provider and/or health care facility in your practice. Providers unable to make updates through the CAQH portal or roster process should contact their Provider Relations Representative for assistance.

Note: Some changes may impact credentialing. Providers are required to notify Molina of changes to credentialing information in accordance with the requirements outlined in the **Credentialing and Recredentialing** section of this Provider Manual.

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods such as letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts its Provider Directory or otherwise impacts its Membership or ability to coordinate Member care. Providers are required to provide timely responses to such communications.

All Molina Providers participating in a Medicaid network must be enrolled in the state Medicaid program to be eligible for reimbursement. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with YES New Mexico at yes.nm.gov and meet the Medicaid Provider enrollment requirements set forth for fee-for-service Providers of the appropriate provider type.

National Plan and Provider Enumeration System (NPPES) Data Verification

In addition to the above verification requirements, the Centers for Medicare & Medicaid Services (CMS) recommends that Providers routinely verify and attest to the accuracy of their NPPES data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider can attest, and NPPES will reflect the attestation date. If the information is incorrect, the Provider can request a change to the record and attest to the changed data, resulting in an updated certification date.

Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov/. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQ) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools whenever possible.
Molina requires all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic claim submission, EFT, ERA, electronic claim appeals, and registration for and use of the Availity portal.
Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Availity portal.
Any Provider entering the network as a Contracted Provider will be required to comply with Molina's electronic solution policy by enrolling for EFT/ERA payments and registering for the Availity portal within 30 days of entering the Molina network.
Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center on our website at MolinaHealthcare.com.

Electronic Solutions/Tools available to Providers

Electronic solutions/tools available to Molina Providers include:

- Electronic claim submission options
- Electronic Payment: EFT with ERA
- Availity portal

Electronic Claim Submission Requirement

Molina strongly encourages participating Providers to submit claims electronically whenever possible. Electronic claim submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance
- Helping to reduce operational costs associated with paper claims (printing, postage, etc.)
- Increasing accuracy of data and efficient information delivery
- Reducing claim processing delays as errors can be corrected and resubmitted electronically
- Eliminating mailing time enabling claims to reach Molina faster

Molina offers the following electronic claims submission options:

- Submit claims directly to Molina via the Availity portal
- Submit claims to Molina through your EDI clearinghouse using Payer ID: 09824

Refer to MolinaHealthcare.com for additional information.
While both options are accepted by Molina, submitting claims via the Availity portal (available to all Providers at no cost) offers a number of additional claim processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper claims.

Availity portal claim submission benefits include:

- Adding attachments to claims
- Submitting corrected claims
- Easily and quickly voiding claims
- Checking claim status
- Receiving timely notification of a change in status for a particular claim
- Saving incomplete/un-submitted claims
- Creating/Managing claim templates

For additional information on EDI claim submission and paper claim submission, please refer to the **Claims and Compensation** section of this Provider Manual.

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required to enroll in EFT and ERA. Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery processes.

Molina has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform you may receive your payment via EFT/Automated Clearing House (ACH), a physical check or a virtual card.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via virtual card. This method may include a fee established between you and your merchant agreement and is not charged by Molina or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your EOP and by contacting ECHO Customer Service at (888) 834-3511 or edi@echohealthinc.com. Once your payment preference has been updated, all payments will go out using the method requested.
Once you have enrolled for electronic payments, you will receive the associated ERAs from ECHO with the Molina Payer ID. Please ensure that your practice management system is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO Provider portal at Providerpayments.com.

If you have any difficulty with the website or have additional questions, ECHO has a Customer Services team available to assist with this transition. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Customer Services team at (888) 834-3511.
As a reminder, Molina's Payer ID is 09824.
Once your account is activated, you will begin receiving all payments through EFT, and you will no longer receive a paper EOP (i.e., remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download, and save historical and new ERAs with a two (2) year lookback.
Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website at MolinaHealthcare.com.

Gross Receipt Tax

Molina will reimburse Gross Receipt Tax (GRT) to applicable Providers who meet the following criteria:

- The Provider's practice is a for-profit entity.
- They are required to pay GRT to the State of New Mexico.

Gross Receipts/Sales tax cannot be added to the charges of any patient who is a Member of a Health Plan or insurer of which a Provider has made an agreement with to accept their reimbursement (Division of Insurance Regulation, 13 NMAC 10.13.27). Information such as tax tables and forms for Gross Receipts tax can be found on the New Mexico Taxation and Revenue Website: State of NM GRT.

Availity Portal

Providers and third-party billers can use the no-cost Availity portal to perform many functions online without the need to call or fax Molina. Registration can be performed online, and once completed, the easy-to-use tool offers the following features:

- Verify and print Member eligibility, covered services and view HEDIS® needed services (gaps).
- Claims:
  - Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) claims (individual or multiple claims)
  - Correct/void claims
  - Add attachments to previously submitted claims
  - Check claim status
  - View ERA and EOP
  - Create and manage claim templates
  - Create and submit a claim Appeal with attached files
- Prior Authorization/Service Requests
  - Create and submit Prior Authorization/Service Requests

    - Check status of Prior Authorization/Service Requests
- Download forms and documents
- Send/receive secure messages to/from Molina
- Access Member care plans

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that Molina's legal obligation to the Provider. Balance billing a Molina Member for services covered by Molina is prohibited except for the Member's applicable copayment, coinsurance and deductible amounts.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's Member materials (such as Member Handbooks).
Please refer to the **Member Rights and Responsibilities** section of this Provider Manual for additional information.

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all state and federal laws and regulations and approved by Molina prior to use.
Providers should contact Molina Provider Relations Representatives for information and review of proposed materials.

Member Eligibility Verification

Possession of a Molina Member ID Card does not guarantee Member eligibility or coverage. Providers should verify the eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.
Providers who contract with Molina may verify a Member's eligibility by checking the following:

- Availity portal
- Molina Provider Contact Center automated IVR system at (855) 322-4078

Member Cost Share

Providers should verify the Molina Member's cost share status prior to requiring the Molina Member to pay copay, coinsurance, deductible or other cost share that may be applicable to

the Member's specific benefit plan.

Health Care Services (Utilization Management and Care Coordination)

Providers are required to participate in and comply with Molina's Utilization Management and care coordination programs, including all policies and procedures regarding Molina's facility admission, prior authorization, and Medical Necessity review determination procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.
For additional information, please refer to the **Health Care Services** section of this Provider Manual.

In-Office Laboratory Tests

Specimen collection is allowed in a Provider's office and shall be compensated in accordance with your Provider Agreement with Molina and applicable state and federal billing and payment rules and regulations.
Additional information regarding In-Network Laboratory Providers and In-Network Laboratory Provider patient service centers is found on the laboratory Providers' respective websites at labcorp.com/labs-and-appointments, appointment.questdiagnostics.com, and tricore.org.

Referrals

A referral is necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals, unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the PCP and specialist to coordinate the patient's care and ensure continuity of care. Providers need to document any referrals that are made in the patient's medical record. Documentation must include the specialty, services requested and diagnosis for which the referral is being made.
Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers contracted and credentialed (if applicable) with Molina. In the case of Emergency Services, Providers may direct Members to an appropriate service, including but not limited to primary care, urgent care, and hospital emergency room. There may be circumstances in which referrals may require an out-of-network Provider. Molina will require prior authorization except in the case of Emergency Services.
For additional information, please refer to the **Health Care Services** section of this Provider Manual.
PCPs can refer a Member to an in-network specialist for consultation and treatment without a referral request to Molina.

Treatment Alternatives and Communication with Members

Molina endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow-up care. Molina promotes open discussion between Providers and Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care, and other measures Members may take to promote their health.

Pharmacy Program

Providers are required to adhere to Molina's drug formularies and prescription policies. For additional information, please refer to the **Pharmacy** section of this Provider Manual.

Participation in Quality Programs

Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to Care Standards
- Site and Medical Record-Keeping Practice Reviews
- Delivery of Patient Care Information

For additional information, please refer to the **Quality** section of this Provider Manual.

Vaccines for Children Program

Molina practitioners in New Mexico must enroll in the Vaccines for Children (VFC) Program. VFC provides vaccines at no charge to immunize Molina Members under the age of 18.

- To enroll with VFC, contact VFC at (866) 681-5872. For more information, please see the New Mexico Immunization Program's website at nmhealth.org/about/phd/idb/imp.
- The New Mexico Statewide Immunization Information System to record immunizations administered in your clinic or health care facility, contact the NMSIIS website at nmsiis.health.state.nm.us/webiznet_nm/Login.

Transition of Care After Termination

All Molina contracted practitioners/Providers terminating their contracted status with Molina, including groups, are required to follow appropriate Transition of Care guidelines for Molina patients under a current course of treatment or care of the terminating Provider or group. This includes seeing Molina patients for no more than 90 calendar days after termination until the Molina patient's current episode of care is resolved or until the Molina patient has been appropriately transitioned to another contracted Molina practitioner/Provider.

The practitioner/Provider will also:

1. Refrain from billing any Molina patients in this 90-day transition period for Covered Services except for any applicable copayments, deductibles and/or coinsurance.
2. Accept the non-par rate reflected in NMAC Program Rules as payment in full during the 90-day transition period or until the Molina patient's episode of care is resolved or is transitioned to another contracted Molina practitioner/Provider.
3. Continue to follow Molina's Utilization Managed policies and procedures.
4. Share any information requested, including medical records, regarding the treatment plan with Molina.

Compliance

Providers must comply with all state and federal Laws and regulations related to the care and management of Molina Members.

Confidentiality of Member Health Information and HIPAA Transactions

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patients and Member protected health information (PHI). For additional information, please refer to the **Compliance** section of this Provider Manual.

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's grievance program and cooperate with Molina in identifying, processing and promptly resolving all Member grievances or inquiries. If a Member has a grievance regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records and/or statements as needed. This includes the maintenance and retention of Member records for a period of not less than 10 years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information, please refer to the **Provider Grievance, Reconsideration and Appeal Processes** section of this Provider Manual.

Participation in Credentialing

Providers are required to participate in Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina and applicable accreditation, state and federal requirements. This includes providing prompt responses to requests for information related to the credentialing or recredentialing process.

For additional information on Molina's credentialing program, please refer to the **Credentialing and Recredentialing** section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegated Services Addendum. For additional information on Molina's delegation requirements and delegation oversight, please refer to the **Delegation** section of this Provider Manual.

Primary Care Provider Responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists participating with Molina
- Triage appropriately
- Notify Molina of Members who may benefit from care coordination
- Participate in the development of care coordination treatment plans

4. CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Background

Molina ensures all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, national origin, sex, age and disability per Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities Act of 1990. Molina will comply with all regulatory requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.
Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com, from your local Provider Relations Representative or by calling the Molina Provider Contact Center at (855) 322-4078.

Nondiscrimination of Healthcare Service Delivery

Molina complies with Section 1557 of the ACA. As a Provider participating in Molina's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR), State law and Federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a member's medical (physical or mental) condition or the expectation of the need for frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found in the Member Handbook located at Member Materials and Forms.
3. You **MUST** post in a conspicuous location in your office, a Tagline Document, which explains how to access non-English language services. A sample of the Tagline Document that you will post can be found in the Member Handbook located at Member Materials and Forms.

4. If a Molina Member needs language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency (LEP). You can find resources on meeting your LEP obligations at hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index and hhs.gov/civil-rights/for-Providers/clearance-medicare-Providers/technical-assistance/limited-english-proficiency/index.
5. If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Toll-Free Phone (866) 606-3889 TTY/TDD, 711 civil.rights@MolinaHealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Website: ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Form: hhs.gov/ocr/complaints/index.html

If you or a Molina Member need additional help or more information, call the Department of Health and Human Services Office of Civil Rights toll-free at (800) 368-1019 or TTY/TDD (800) 537-7697.

Cultural Competency

Molina is committed to reducing health care disparities. Training employees, Providers and their staffs, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina integrates cultural competency training into the overall Provider training and quality monitoring programs. An integrated quality approach intends to enhance the way people think about our Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and Community-Based Organizations. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Relations or online/web-based training modules. Web-based training modules can be found on Molina's website at MolinaHealthcare.com.

Training modules, delivered through a variety of methods, include:

1. Provider written communications and resource materials

2. On-site cultural competency training
3. Online cultural competency Provider training modules
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Integrated Quality Improvement

Molina ensures Members access to language services such as oral interpretation, American Sign Language (ASL), and written translation. Molina must also ensure access to programs, aids and services that are congruent with cultural norms. Molina supports Members with disabilities and assists Members with Limited English Proficient (LEP).
Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats (i.e., Braille, audio, large print), leading to better communication, understanding, and Member satisfaction. Online materials found on MolinaHealthcare.com and information delivered in digital form must meet Section 508 accessibility requirements to support Members with visual impairments.
Key Member information, including appeal and grievance forms, are also available in threshold languages on the Molina Member website.

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Provider Contact Center at (855) 322-4078. If Molina Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified language service provider.
Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Members interpreter services if the Members do not request them on their own. Please remember asking a family member, friend or minor to interpret is never permissible.
All eligible Members with LEP are entitled to receive interpreter services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency (LRP) or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Molina is available to assist Providers with locating these services if needed.

An individual with LEP has a limited ability or inability to read, speak or write English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations).

Molina Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973 and the Civil Rights Act of 1964.
- Be given access to Care Coordinators trained to work with individuals with cognitive impairments.
- Be notified by the medical Provider that interpreter services are available at no cost.
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
    - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records.
    - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf.
    - Interpreters must ensure that this shared information is similarly safeguarded.
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.

Interpreters include people who can speak the Member's native language, assist with a disability, or help the Member understand the information.

When Molina Members need an interpreter, limited hearing services, and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited hearing services, and/or limited reading services are available.
- Molina is available to assist Providers with locating these services if needed:
    - Providers needing assistance finding onsite interpreter services.
    - Providers needing assistance finding translation services.
    - Providers with Members who cannot hear or have limited hearing ability may use the National TTY/TDD Relay service at 711.
    - Providers with Members with limited vision may contact Molina for documents in large print, Braille, or audio version.
    - Providers with Members with LRP can contact the Molina Member Services Contact Center and a representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

Documentation

As a contracted Molina Provider, your responsibilities for documenting Member language services/needs in the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you monthly by Molina.

- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a member insists on using a family member, friend or minor as an interpreter or refuses to use interpreter services after notification of his or her right to have a qualified interpreter at no cost.

Members Who are Deaf or Hard of Hearing

Molina strongly recommends that Provider offices make available assistive listening devices for Members who are deaf or hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.
Molina will provide face-to-face service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made at least three (3) business days before an appointment to ensure service availability. In most cases, Members will have made this request via Molina Member Services.
TTY/TDD connection is accessible by dialing 711. This connection provides access to Molina Member Services and Provider Contact Center, Quality, Health Care Services, and all other health plan functions.

24-Hour Nurse Advice Line

Molina provides nurse advice services for Members 24 hours per day, 7 days per week. The 24-hour Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's 24-Hour Nurse Advice Line directly at (833) 965-1558 or TTY/TDD 711. The 24-Hour Nurse Advice Line telephone number is also printed on Molina Member ID cards.

Program and Policy Review Guidelines

Molina conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its Members and Providers:

- Annual collection and analysis of race, ethnicity, and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within plan's Membership.
  - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Needs Assessment).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.

- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS® results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

5. MEMBER ELIGIBILITY, ENROLLMENT AND HEALTH ASSESSMENT

Member Eligibility

HCA determines eligibility for enrollment in the Turquoise Care Program. All individuals determined to be Medicaid eligible are required to participate in the Turquoise Care Program unless he or she is: (1) a Native American and elects enrollment in the Medical Assistance Division's fee-for-service (FFS) program; or (2) is in an excluded population.
A Native American who does not meet a nursing facility level of care, intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care or is not dually eligible for both Medicaid and Medicare will not be enrolled in the Turquoise Care Program unless the eligible recipient elects to enroll.

The following eligible recipients are excluded from Turquoise Care Program enrollment:

- Qualified Medicare beneficiaries (QMB)-only recipients
- Specified low-income Medicare beneficiaries
- Qualified individuals
- Qualified disabled working individuals
- Refugees
- Participants in the program for all-inclusive care for the elderly (PACE)
- Children and adolescents in out-of-state foster or adoption placements

No eligible Member shall be refused enrollment or re-enrollment, have their enrollment terminated, or be discriminated against in any way because of their health status or pre-existing physical or mental condition, including pregnancy, hospitalization, or the need for frequent or high-cost care.

Member Enrollment

HCA will enroll individuals who are determined eligible for Turquoise Care. Enrollment with Molina may be the result of a recipient's selection or assignment by HCA.

Upon Enrollment with Molina, Members receive a Welcome Packet that includes:

- Welcome Letter with ID Card. This includes how to select a new PCP.
- Quick Start Guide (QRG) that includes important information on their benefits and services as well as the following:
  - How to access care
  - What is an emergency
  - How to reach the 24-Hour Nurse Advice Line
  - How to access the Member Handbook, Provider Directory, and the Preferred Drug List on Molina's Public Website as well as how to request them in an alternative format, to include print.

Turquoise Care Members enrolled with Molina are provided with an identification card. The card includes:

1. Telephone numbers for information and/or authorizations, including for physical health, behavioral health and long-term care supports services
2. Description of procedures to be followed for emergency or special services
3. Member identification number, name, date of birth, enrollment effective date and PCP
4. Member co-payment amounts for covered services

The back of Molina's Member identification card provides important information on obtaining services and telephone numbers for our Providers and Members to utilize as needed.

At each office visit, your office staff should:

1. Ask for the Molina Member ID Card.
2. Copy both sides of the Molina Member ID Card and keep the copy with the patient's files.
3. Determine if the Member is covered by another health plan and record information for coordination of benefits. If another health plan covers the Member, the Provider must submit to the other carrier(s) first. After the other carrier(s) pay, submit the claim to Molina.

Newborn Enrollment

For mothers assigned to Molina and enrolled in Turquoise Care, the hospital or other servicing Provider must complete a Notification of Birth. The newborn is effective upon completion of the eligibility process. The Newborn is eligible for a period of 13 months starting with the month of birth.

Eligibility Verification

Medicaid Programs

The State of New Mexico, through HCA, determines eligibility for the Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility Listing for Medicaid Programs

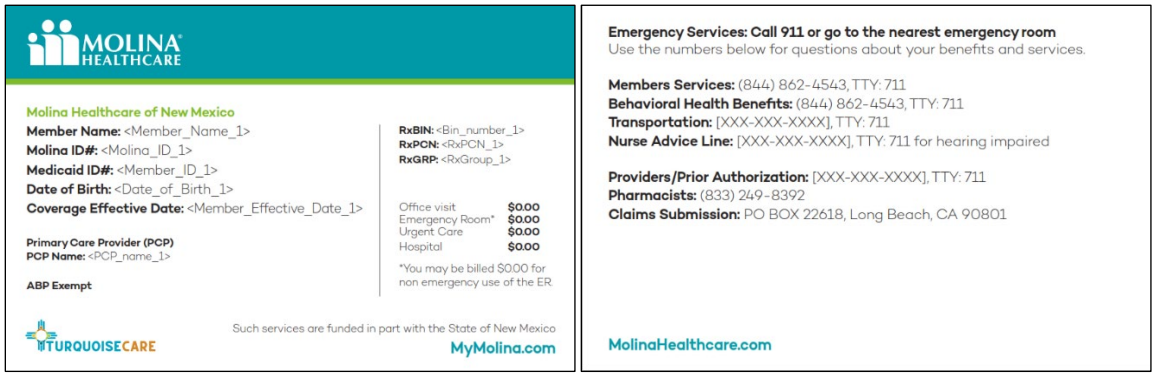
Providers who contract with Molina may verify a member's eligibility and/or confirm PCP assignment by checking the following:

- Molina Provider Contact Center automated IVR system at (855) 322-4078
- Eligibility can also be verified through the state at New Mexico Medicaid Portal (conduent.com).
- Availity portal

Possession of a Molina Member ID Card does not mean a recipient is eligible for Medicaid services. A Provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information.

Identification Cards

Molina Sample Member ID Cards



Members may qualify for the Alternative Benefit Plan due to their category of eligibility based on income level, which has copayment requirements for some covered services.

Members are reminded in their Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment prior to rendering services. Unless an emergency medical condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment Initiated by Member

A Member, other than a Child in State Custody (CISC) Member, may request to be disenrolled from Molina and change MCOs during the first 90 Calendar Days following the effective date of enrollment with Molina. A Member, including a CISC Member, may request to be disenrolled from Molina for cause at any time, even during a lock-in period. The Member must submit a written request to HCA for approval.
Voluntary disenrollment does not preclude Members from filing a grievance with Molina for incidents occurring during the time they were covered with Molina.

Involuntary Disenrollment Initiated by HCA

A Member may be disenrolled by HCA if the Member loses Medicaid eligibility; or when it is determined during the Fair Hearing process that disenrollment is in the best interest of the Member and/or HCA.

PCP Assignment

After a member has been enrolled for 15 calendar days, a PCP is assigned to the Member except Dual Eligible Members (enrolled in both Medicaid and Medicare who are assigned or have previously selected a PCP accepting Medicare). The Member will receive an identification card showing the assigned PCP. ID cards for Dual Eligible Members will not reflect a PCP. Individual family Members may choose the same or different PCPs.

Members may choose a PCP from the list of participating practitioners in one of the following specialties:

1. Family Practice, General Practice
2. Certified Nurse Practitioners and Physician Assistants
3. Internal Medicine
4. Gerontology
5. Pediatrics
6. OB/GYN – Female Members may self-refer to a women's health care Provider. Some OB/GYNs act as PCPs. In this case, the OB/GYN is listed under the Primary Care Section of the Provider Directory.
7. Specialists, on an individualized basis, for Members whose care is more appropriately managed by a specialist, such as Members with infectious diseases, chronic illness, etc. A board-certified psychiatrist may serve as a PCP for Members with complex behavioral health conditions or disabilities.
8. I/T/Us (Indian Health Services, Tribal 638 and Urban Indian Providers may be designated as PCPs as appropriate)

PCP Changes

Member Initiated

Members may change their PCP at any time, for any reason. Members who wish to change their PCP may use the Member Portal available at MyMolina.com or call Molina Member Services at (844) 862-4543. When a Member changes PCPs, Molina will issue a new identification card to the Member. If the change is requested by the 20th of the month, it will be effective on the first day of the following month. If the request is made after the 20th day, it will become effective the first day of the second month following the request.
Members presenting at a PCP's office **to whom they are not assigned** may request a change of PCP by filling out and signing a "Member Authorization to Change Primary Care Practitioner"

Form. The form should then be faxed or emailed to Molina, and a new identification card will be sent to the Member. This form may be found at PCP Change Form.

PCP Initiated

Molina asks that you document the need for these changes in writing to the Provider Contact Center, with the specific reasons for the request. Reasonable cause does not include a member's health status. Please submit documentation to:
Molina Healthcare of New Mexico, Inc.
Provider Contact Center
P.O. Box 3887
Albuquerque, NM 87190
Fax: (505) 798-7313

PCPs are responsible for providing basic care and emergency coverage for up to 30 days after the date of your change letter or until we can confirm the Member has changed their PCP, whichever is less. The PCP initiating the Member's change is responsible for copying and transferring the Member's medical records to the new PCP.

Molina Initiated Change of PCP

Molina may initiate a PCP change for a Member under the following circumstances:

1. Molina and the Member agree that assignment to a different PCP is in the Member's best interest, based on the Member's medical condition
2. A Member's PCP ceases to be a Molina-contracted Practitioner
3. A Member's behavior toward the PCP is such that it is not feasible to safely or prudently provide medical care, and the PCP has made reasonable efforts to accommodate the Member
4. A Member has initiated legal action against the PCP
5. The PCP is suspended for any reason
6. Based on claims data, Members will be automatically reassigned to the PCP they are seeing, rather than the one initially assigned through the PCP auto-assignment process. This "re-paneling" process will be executed on the 20th of each month. Establishing accurate panels will allow Molina to appropriately measure primary care utilization and capacity, assess patient characteristics, and generate clinical quality indicators based on an accurate denominator. This will also allow Molina staff and the Member's PCP to better direct outreach and quality initiatives to the appropriate Members.

PCP/Medical Practitioner Lock-In

When concerns about misuse of unnecessary services and/or prescription drugs by a Member are identified, Molina may place a member into "lock-in." This program is called Patient Review and Restriction. Enrollment in this Program is usually for 12 months.

Molina may require that a Member see a certain PCP while ensuring reasonable access to quality services when:

1. Utilized services have been identified as unnecessary.
2. A Member's behavior is detrimental.
3. A need is indicated to provide care continuity.

Molina utilizes claims data, emergency room reports, pharmacy claims reports, New Mexico Prescription Monitoring Program reports, Care Coordination Referral Forms, Provider Grievances and 24-Hour Nurse Advice Line reports to identify when a Member's behavior requires placement into lock-in.
Identified behaviors include, but are not limited to, excessive emergency room utilization, excessive PCP change requests, Provider reports of drug demands when not medically indicated, non-compliance to treatment plans, self-referral to pain management Providers, and excessive "no-shows" to Provider appointments.

A Member may be considered for lock-in if their utilization history shows:

1. Any of the following conditions have been met or exceeded in a 90-day period within the past year:
    a. Received services from four (4) or more different Practitioners
    b. Had controlled substance prescriptions filled by three (3) or more different pharmacies
    c. Received excessive prescriptions and/or quantities of controlled substances as documented in Rx claims history and/or New Mexico Prescription Monitoring Program reports
    d. Received controlled substance prescriptions from three (3) or more different prescribers not in the same medical practice, especially emergency department Providers
    e. Received opioid prescriptions while on opioid replacement therapy
    f. Received similar services from two (2) or more practitioners on the same day
2. The Member has made two (2) or more visits to emergency departments for similar services within a 90-day period in the past year.
3. The Member has a medical history of at-risk utilization patterns within the past year.
4. The Member has made repeated and documented efforts to seek medically unnecessary health services within the past year and has been counseled at least once by a health care Provider or managed care plan representative about the appropriate use of health care services.

When the conditions listed above are met, a Medical Director reviews the Member's diagnosis, history of services provided, or other relevant medical information (e.g., prescription claims history). The Medical Director must determine that the documented utilization shows both of the following:

1. That the utilization is all related to one problem and is not an unlucky coincidence of appropriate treatment for several different problems.

2. That continuation of services from multiple Providers constitutes inappropriate, unsafe, or medically unnecessary medical practice or overuse of medical services (as defined in applicable New Mexico statutes and regulations) well beyond the patient's medically necessary care.

If the Medical Director finds that the Member is using inappropriate, unsafe, or medically unnecessary services, Molina staff will follow policies and procedures to initiate restrictions.

Prior to placing a Member into medical Provider lock-in, Molina will inform the Member and/or Member's representative of the intent to lock-in, including the reasons for imposing the lock-in. The restriction does not apply to emergency services furnished to the Member.

The Member's input will be required to select an assigned medical Practitioner for lock-in. Depending on circumstances, this Practitioner may be the Member's PCP, pain specialist, oncologist, Suboxone or methadone Provider, or another medical Practitioner who has a relationship with the Member and a reason to provide the Member with prescriptions for drugs with abuse potential. The medical Practitioner chosen by the Member must be agreeable to acting as the Practitioner and manager of the Member's prescriptions for medications with abuse potential. Molina's grievance procedure will be made available to a Member disagreeing with the lock-in process.

The lock-in will be reviewed and documented by Molina and reported to HCA every month. The Member will be removed from lock-in when Molina has determined that the utilization problems or detrimental behavior has ceased, and that recurrence of the problems is judged to be improbable. HCA will be notified of all lock-in removals.

Criteria for ending lock-in for a Member are as follows:

1. The Member has been in the program for 12 months.
2. Review of clinical, prescribing and billing information shows that the Member's care has been reasonable and appropriate or the PCP handling the lock-in restrictions reports that the services requested have been reasonable and appropriate.
3. One of the following early-termination criteria is met:
    a. The Member disenrolls or otherwise leaves the plan.
    b. The Member's health status changes and the program is no longer necessary or is a hindrance to ongoing medical care.

Transition of Care for New Molina Members

Molina will authorize medically necessary health care services for a new Member who has been authorized to receive these services by their previous Medicaid health plan, the Health Insurance Marketplace, and/or fee-for-service Medicaid upon enrollment to Molina as defined by State regulation.

The utilization reviewer and/or care coordinator will contact the new Member and the new Member's current Practitioner/Provider to determine the transition of care needs of the Member to a Molina contracted Practitioner/Provider.

Continuity of Care

Continuity of Care Following Transition between Two Managed Care Organizations (MCOs)

Practitioners/Providers will receive pertinent Member information, with Member consent, when the Member transitions from one managed care organization to another, including information related to key medical conditions, authorization data, assessment results, and service coordination and/or care coordination status, including a copy of the current Care Plan.

Continuity of Care Following Member Loss of Eligibility

If the Member's eligibility ends and the Member needs continued treatment, Molina will inform the Member of alternative options for care that may be available through a local or State agency.

Continuity of Care and Communication after Practitioner Termination

Molina's policy is to give Members advance notice when a Provider they see will no longer be in the network. Members and Provider are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out-of-network Provider for a given time.

Molina stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers, and the Member's PCP. Information should be shared to facilitate communication of urgent needs or significant findings.

Molina allows any Member whose treating Practitioner leaves the network during an episode of care, to continue diagnostic or therapeutic endeavors with that Practitioner until the current episode of care (an active course of treatment for an acute medical condition or ongoing treatment of a chronic medical condition) terminates or until 90 days have elapsed since the Practitioner's contract ended, whichever is shorter. Molina will authorize this continuity of care only if the health care Practitioner/Provider agrees to:

a. Accept reimbursement from Molina at the rates applicable before the transitional period starts as full payment.
b. Adhere to Molina's quality assurance requirements and provide Molina with necessary medical information related to such care.

Under no circumstances will Members be permitted to continue care with Practitioners/Providers who have been terminated from the network for quality of care, barred from participation based on existing Medicare, Medicaid, or Health Insurance Marketplace sanctions or fraud reasons.
For additional information regarding continuity of care and transition of Members, please contact Molina toll-free at (855) 322-4078.

Member Notification of PCP and Specialist Termination

Molina will notify Members in writing of their PCP's termination by the later of 30 calendar days prior to the effective date the termination or 15 Calendar Days after receipt or issuance of the termination notice. A notification will be sent to a Member who received their Primary Care from, or was seen on a regular basis by, the terminated Provider. A new Molina identification card is mailed to the Member reflecting their choice of a new PCP or assignment to a new PCP.

Molina will notify the Member in writing of their specialist's termination when the Member has received services from the terminating specialist within the previous 90 days from the date Molina receives or issues the termination notice.

Molina Care Coordinators will work with Providers to gather information needed to create a transition plan, some of which is required to submit to the New Mexico Health Care Authority if the termination of any one Provider is deemed substantial.

Member Health Assessment

Molina will identify Members with complex physical and/or behavioral health needs through screening and health assessments performed by Care Coordinators at the time of enrollment. The staff will obtain basic health demographic information to complete a Health Risk Assessment (HRA). The HRA results will determine the necessary level of care coordination, identify any cultural or disability sensitivities and determine the need for a Comprehensive Needs Assessment (CNA).
The results of the HRA will be communicated to Molina's Care Coordination team for evaluation of the appropriate level of care and any special accommodations. Members identified will be referred for the appropriate level of Care Coordination, and a Molina Care Coordinator will develop a Care Plan to address the Members' functional needs, medical conditions, behavioral health needs, and social and environmental needs in collaboration with the Member's family, PCP, and other professional practitioners/Providers or agencies involved in their care.
The Care Coordination Queue is available during normal business hours Monday through Friday, from 8 a.m.-5 p.m., MT. Please call or refer Members to toll-free (844) 862-4543.

6. MEMBER RIGHTS AND RESPONSIBILITIES

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The most current Member Rights and Responsibilities can be accessed via the following link: MolinaHealthcare.com.
Member Handbooks are available on Molina's Member website. Member Rights and Responsibilities are outlined under the heading "Rights and responsibilities" within the Member Handbook document.
State and federal law requires that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care, and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.
For additional information, please contact the Molina Contact Center at (855) 322-4078. TTY users, please call 711.

Second Opinions

Members have the right to a second opinion from a qualified health care professional with Molina's network. Members should call the Member Services Contact Center to find out how to get a second opinion. Second opinions may require Prior Authorization.

Member Rights

1. Members or their authorized representatives have a right to receive information about Molina, Molina's policies and procedures regarding products, services, its contracted Practitioners and Providers, grievance procedures, benefits provided and Member rights and responsibilities.
2. Members have a right to be treated with courtesy and consideration, equitably and with respect and recognition of their dignity and right and need for privacy.
3. Members or their authorized representatives have a right to choose a PCP within the limits of the covered benefits and plan network, and the right to refuse care of specific Practitioners or to notify the Provider if changes need to be requested.
4. Members or their authorized representatives have a right to receive from the Member's Practitioner/Provider, in terms that the Member or authorized representative(s) understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of the health care insurers or Molina's position on treatment options. If the Member cannot understand the information, the explanation be provided to his or her next of kin, guardian, agent, or surrogate, if available, and documented in the Member's medical record.
5. Members have a right to receive health care services in a non-discriminatory fashion.
6. Members who do not speak English as their first language have the right to access translator services at no cost for communication with Molina.

7. Members who have a disability have the right to receive information in an alternative format in compliance with the Americans with Disabilities Act.
8. Members or their authorized representatives have a right to participate with their health care Practitioner/Provider in decision making in all aspects of their health care, including the treatment plan development, acceptable treatments, and the right to refuse treatment.
9. Members or their authorized representatives have the right to informed consent.
10. Members or their authorized representatives have the right to choose a surrogate decision-maker to be involved, as appropriate, to assist with care decisions.
11. Members or their authorized representatives have the right to seek a second opinion from another Provider in the Molina network when Members need additional information regarding recommended treatment or believe the Provider is not authorizing requested care.
12. Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
13. Members or their authorized representatives have a right to voice, grievances or appeals about Molina, the handling of grievances, or the care provided and make use of Molina's grievance process and the Human Service Department (HCA) hearings process, at no cost, without fear of retaliation.
14. Members or their authorized representatives have a right to file a grievance or appeal with Molina or the HCA Administrative Hearings Bureau, for Medicaid Members, and to receive an answer to those grievances or appeals within a reasonable time.
15. Members or their authorized representatives have a right to choose from among the available Practitioners and Providers within the limits of Molina's network and its referral and prior authorization requirements.
16. Members or their authorized representatives have a right to make their decisions known through advance directives regarding health care decisions (i.e., living wills, right-to-die directives, "do not resuscitate" orders, etc.) consistent with Federal and State laws and regulations.
17. Members or their authorized representatives have a right to the privacy of medical and financial records maintained by Molina and its Providers, in accordance with existing law.
18. Members or their authorized representatives have a right to access the Member's medical records in accordance with the applicable Federal and State laws and regulations.
19. Members can consent to or deny the release of identifiable medical or other information by Molina, except when such release is required by law.
20. Members have a right to request an amendment to their Protected Health Information (PHI) if the information is believed to be incomplete or wrong.
21. Members or their authorized representatives have a right to receive information about Molina, its health care services, how to access those services, the network Practitioners and Providers (i.e., title and education) and the Patient Bill of Rights.
22. Members or their authorized representatives have a right to be provided with information concerning Molina's policies and procedures regarding products, services,

Practitioners and Providers, appeal procedures, obtaining consent for use of Member medical information, allowing Members access to their medical records, and protecting access to Member medical information, and other information about Molina and benefits provided.

23. Members or their authorized representatives have a right to know upon request of any financial arrangements or provisions between Molina and its Practitioners and Providers which may restrict referral or treatment options or limit the services offered to Members.
24. Members or their authorized representatives have a right to be free from harassment by Molina or its network Practitioners or Providers in regard to contractual disputes between Molina and Practitioners or Providers.
25. Members or their authorized representatives have a right to available and accessible services when medically necessary as determined by the PCP or treating Provider in consultation with Molina, 24 hours per day, seven (7) days per week for urgent or emergency care services, and for other health care services as defined by the contract or evidence of coverage.
26. Members have a right to adequate access to qualified health professionals near where the Member lives or works, within the service area of Molina.
27. Members have a right to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a non-participating Provider, and an explanation of a Member's financial responsibility when services are provided by a non-participating Provider/or non-participating Practitioner, or provided without required pre-authorization.
28. Members or their authorized representatives have a right to prompt notification of termination or changes in benefits, services, or Provider network.
29. Members have a right to seek care from a non-participating Provider and be advised of their financial responsibility if they receive services from a non-participating Provider or receive services without required Prior Authorization.
30. Members have the right to continue an ongoing course of treatment for a period of at least 30 calendar days. This will apply if the Member's Provider leaves the Provider network, or if a new Member's Provider is not in the Provider network.
31. Members have the right to make recommendations regarding the organization's Member Rights and Responsibilities policy.
32. Members have a right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
33. Members or their authorized representatives will have the right to select a Managed Care Organization (MCO) and exercise switch enrollment rights without threats or harassment.
34. Members have a right to detailed information about coverage, maximum benefits and exclusions of specific conditions, ailments, or disorders, including restricted benefits and all requirements that an enrollee must follow for prior approval and utilization review.
35. Members or their authorized representatives have all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse

medication and treatment after possible consequences of this decision have been explained in language the Member understands.

36. Members or their authorized representatives have the right to a complete explanation of why care is denied, an opportunity to appeal the decision to Molina's internal review, the right to a secondary appeal, and the right to request the superintendent's or HCA's assistance as applicable.
37. Members or their authorized representatives have the right to get information, when they ask, that HCA determines is important during the Member's first contact with the MCO. This information can include a request for information about the MCO's structure, operation and/or Practitioners or senior staff's incentive plans.
38. Members or their authorized representative are free to exercise their rights and exercising those rights will not result in adverse treatment of the Member or their authorized representative.

Member Responsibilities

Molina enrolled Members and/or their guardian(s) has the responsibility to:

1. Provide, to the extent possible, information that Molina and its Providers need to care for them.
2. Understand the Member's health problems and to participate in developing mutually agreed upon treatment goals.
3. Follow the plans and care instructions they agreed on with their Practitioner(s).
4. Keep, reschedule, or cancel an appointment rather than to simply fail to show-up.
5. Review their Member Handbook or Evidence of Coverage and if there are questions contact the Member Services department for clarification of benefits, limitations, and exclusions. The Member Services telephone number is located on the Member's Identification Card.
6. Follow Molina's policies, procedures, and instructions for obtaining services and care.
7. Show their Member Identification Card each time they go for medical care and to notify Molina immediately of any loss or theft of their identification card.
8. Advise a participating Provider of coverage with Molina at the time of service. Members may be required to pay for services if they do not inform the participating Provider of their coverage.
9. Pay for all services obtained prior to the effective date with Molina and subsequent to termination or cancellation of coverage with Molina.
10. Notify their Income Support Division Caseworker if there is a change in their name, address, telephone number, or any changes in their family.
11. Notify HCA and Molina if they get medical coverage other than through Molina.
12. Pay for all required copayments and/or coinsurance at the time services are rendered.

7. TURQUOISE CARE COVERED SERVICES

Molina provides and coordinates comprehensive and integrated health care benefits to each of its enrolled Members and covers the physical health, behavioral health and long-term LTSS benefits as directed by HCA.

Turquoise Care Covered Services

- Accredited Residential Treatment Center Services
- Adult Psychological Rehabilitation Services
- Ambulatory Surgical Center Services
- Anesthesia Services
- Applied Behavior Analysis
- Assertive Community Treatment Services
- Behavior Management Skills Development Services
- Behavioral Health Professional Services: outpatient behavioral health and substance Care Coordination
- Community Interveners for the Deaf and Blind
- Comprehensive Community Support Services
- Day Treatment Services
- Dental Services
- Diagnostic Imaging and Therapeutic Radiology Services
- Dialysis Services
- Durable Medical Equipment and Supplies
- Emergency Services (including emergency room visits and psychiatric ER
- Experimental or Investigational Procedures, Technology or Non-Drug Therapies[1]
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- EPSDT Personal Care Services
- EPSDT Private Duty Nursing
- EPSDT Rehabilitation Services
- Family Planning
- Family Support (Behavioral Health)
- Federally Qualified Health Center Services
- Hearing Aids and Related Evaluations
- Home Health Services
- Hospice Services
- Hospital Inpatient (including detoxification services)
- Hospital Outpatient
- Inpatient Hospitalization in Freestanding Psychiatric Hospitals
- Intensive Outpatient Program Services
- IV Outpatient Services
- Laboratory Services

- Medication Assisted Treatment for Opioid Dependence
- Midwife Services
- Multi-Systemic Therapy Services
- Non-Accredited Residential Treatment Centers and Group Homes
- Nursing Facility Services
- Nutritional Services
- Occupational Services
- Outpatient Hospital based Psychiatric Services and Partial Hospitalization
- Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital
- Outpatient Health Care Professional Services
- Pharmacy Services
- Physical Health Services
- Physical Therapy
- Physician Visits
- Podiatry Services
- Pregnancy Termination Procedures
- Preventive Services
- Prosthetics and Orthotics
- Psychosocial Rehabilitation Services
- Radiology Facilities
- Recovery Services (Behavioral Health)
- Rehabilitation Option Services
- Rehabilitation Services Providers
- Reproductive Health Services
- Respite (Behavioral Health)
- Rural Health Clinics Services
- School-Based Services
- Smoking Cessation Services
- Speech and Language Therapy
- Swing Bed Hospital Services
- Telehealth Services
- Tot-to-Teen Healthcheck
- Transplant Services
- Transportation Services (medical)
- Treatment Foster Care
- Treatment Foster Care II
- Vision Care Services

Community Benefit Covered Services

For Members meeting nursing facility level of care, Molina provides the Community Benefit, as determined appropriate based on the Member's Comprehensive Needs Assessment.

Community Benefit means both the Agency-Based Community Benefit and the Self-Directed Community Benefit subject to an individual's annual allotment as determined by HCA. Members eligible for Community Benefit can select Agency-Based Community Benefit or Self-Directed Community Benefit.

1. Members selecting the Agency-Based Community Benefit will have the option to select their personal care service Provider.
2. Members may also select the Self-Directed Community Benefit, which affords them the opportunity to have choice and control over how services are provided and how much certain Providers are reimbursed in accordance with range of rates per service established by HCA.

Agency-Based Community Benefit Services

- Adult Day Health
- Assisted Living
- Behavior Support Consultation
- Community Transition Services
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Nutritional Counseling
- Personal Care Services
- Private Duty Nursing for Adults
- Respite
- Skilled Maintenance Therapy Services

Self-Directed Community Benefit Services

- Behavior Support Consultation
- Customized Community Support
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Homemaker/Personal Care
- Nutritional Counseling
- Private Duty Nursing for Adults
- Related Goods
- Respite
- Skilled Maintenance Therapy Services
- Specialized Therapies
- Transportation (non-medical)

Alternative Benefit Plan (ABP) - Covered Services

The Alternative Benefit Plan (ABP) is a low-cost insurance plan for adults ages 19 to 64. Under ABP, there are no cost-sharing amounts based on Federal Poverty Level (FPL) percentages. This will impact newly eligible adults up to 138% of FPL.

- Allergy testing and injections
- Annual physical exam and consultation[1]
- Autism spectrum disorder (through age 22) [2]
- Bariatric surgery[3]
- Behavioral health professional and substance abuse services, evaluations, testing, assessments, therapies, and medication management
- Cancer clinical trials
- Cardiac rehabilitation[4]
- Chemotherapy
- Dental services[5]
- Diabetes treatment, including diabetic shoes, medical supplies, equipment, and education
- Dialysis
- Diagnostic imaging
- Disease management
- Drug/Alcohol dependency treatment services, including outpatient detoxification, therapy, partial hospitalization, and intensive outpatient program (IOP) services
- Durable medical equipment, medical supplies, orthotic appliances, and prosthetic devices, including repair or replacement[6]
- EPSDT services, including routine oral and vision care, for individuals aged 19 and 20
- Electroconvulsive therapy
- Emergency services, including emergency room visits, emergency transportation, psychiatric emergencies, and emergency dental care
- Family planning and reproductive health services and devices, sterilization, pregnancy termination and contraceptives[7]
- Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services

[1] Includes a health appraisal exam, laboratory and radiological tests and early detection procedures.
[2] Covers speech, occupational and physical therapy, and applied behavioral analysis for recipients' age 1920; or age 21-22 who are enrolled in high school.
[3] Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight, BMI and health status.
[4] Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight, BMI and health status.
[5] The ABP covers dental services for adults in accordance with 8.3.10.7 NMAC. Recipients age 19-20 may receive dental services according to the increased periodicity under EPSDT.
[6] Requires a Provider's prescription. DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics, including shoes and arch supports, are covered only when an integral part of a leg brace, or are diabetic shoes.
[7] Sterilization reversal is not covered. Infertility treatment is not covered.

- Genetic evaluation and testing[8]
- Habilitative and rehabilitative services, including physical, speech and occupational therapy[9]
- Hearing screening as part of a routine health exam[10]
- Holter monitors and cardiac event monitors
- Home health, skilled nursing, and intravenous services[11]
- Hospice care services
- Hospital inpatient and outpatient services
- Immunizations[12]
- Inhalation therapy
- Inpatient physical and behavioral health hospital/medical services and surgical care[13]
- Inpatient rehabilitative services/facilities[14]
- IV infusions
- Lab tests, x-ray services and pathology
- Maternity care, including delivery and inpatient maternity services and pre- and postnatal care
- Mammography, colorectal cancer screenings, pap smears, PSA tests and other age-appropriate tests
- Medication assisted treatment for opioid dependence
- Non-emergency transportation when necessary to secure covered medical services and/or treatment
- Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity
- Organ and Tissue Transplants[15]
- Osteoporosis diagnosis, treatment, and management
- Outpatient Surgery
- Over-the-counter medicines – prenatal drug items and low-dose aspiring as preventive for cardiac conditions[16]

[8] Limited to Triple Serum Test and genetic testing for the diagnosis or treatment of a current illness. Does not include random genetic screening.
[9] Limited to short-term therapy (two consecutive months) per condition.
[10] Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for recipients age 19-20.
[11] Home health is limited to 100 visits per year. A visit cannot exceed four hours.
[12] Includes ACIP-recommended vaccines
[13] Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification. The ABP does not include inpatient drug rehabilitation services. Free-standing psychiatric hospitals (or Institutions for Mental Disease) are not covered under the ABP or ABP-exempt package except for recipients age 19-20. Surgeries for cosmetic purposes are not covered.
[14] Includes services in a nursing or long-term care acute rehabilitation facility/hospital. Coverage is limited to temporary stays as a step-down level of care from an acute care hospital when medically necessary and the discharge plan for the recipient is the eventual return home.
[15] Transplants are limited to two per lifetime.
[16] Other over-the-counter items may be considered for coverage only when the item is considered more medically or economically appropriate than a prescription drug, contraceptive drug or device, or for treating diabetes

- Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol, and other preventive/diagnostic care and screenings[17]
- Physician visits
- Podiatry and foot care[18]
- Prescription medicines
- Primary care to treat illness/injury
- Pulmonary therapy[19]
- Radiation therapy
- Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects, or disease
- Skilled nursing[20]
- Sleep studies[21]
- Smoking cessation treatment
- Specialist visits
- Specialized behavioral health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PRR)[22]
- Telemedicine services
- Urgent care services/facilities
- Vision care for eye injury or disease[23]
- Vision hardware (eyeglasses or contact lenses) [24]

[17] Includes US Preventive Services Task Force "A" and "B" recommendations, preventive care and screening recommendations of the HRSA Bright Future program and additional preventive services for women recommended by the Institute of Medicine.
[18] Covered when medically necessary due to malformations, injury, acute trauma or diabetes.
[19] Limited to short-term therapy (two consecutive months) per condition.
[20] Subject to the 100-visit home health limited when provided through a home health agency.
[21] Limited to diagnostic sleep studies performed by certified Providers/facilities.
[22] The ABP does not cover behavioral health supportive services: Family Support, Recovery Services and Respite services.
[23] Refraction for visual acuity and routine vision are not covered, except for recipients age 19-20.
[24] Covered only following the removal of the lens from one or both eyes (aphakia). Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery, within 90 days following surgery. Vision hardware is covered for recipients age 19-20 following a periodicity schedule.

8. HEALTH CARE SERVICES (HCS)

Introduction

Health Care Services is comprised of Utilization Management (UM) and Care Coordination (CC) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina provides CC services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina UM program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, medical necessity review and restrictions on the use of out-of-network or non-participating Providers.

Utilization Management (UM)

Molina ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective, and medically appropriate services offered across a continuum of care and integrating a range of services appropriate to meet individual needs. Molina's UM program maintains flexibility to adapt to changes in the Member's condition and is designed to influence a Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care.
- Evaluating the medical necessity and efficiency of health care services across the continuum of care.
- Defining the review criteria, information sources and processes that are used to review and approve the provision of items and services, including prescription drugs.
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization.
- Implementing comprehensive processes to monitor and control the utilization of health care resources.
- Ensuring services are available in a timely manner, in appropriate settings, and are planned, individualized and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring qualified health care professionals perform all components of the UM processes.
- Ensuring UM decision making tools are appropriately applied in determining medical necessity decision.

Key Functions of the UM Program

All prior authorizations are based on a specific standardized list of services. The key functions of the UM program are listed below:

- **Eligibility and Oversight**
  - Eligibility verification
  - Benefit administration and interpretation
  - Verification that authorized care correlates to Member's medical necessity need(s) & benefit plan
  - Verifying of current Physician/hospital contract status
- **Resource Management**
  - Prior Authorization and referral management
  - Admission and Inpatient Review
  - Referrals for Discharge Planning and Care Transitions
  - Staff education on consistent application of UM functions
- **Quality Management**
  - Evaluate satisfaction of the UM program using Member and Provider input
  - Utilization data analysis
  - Monitor for possible over- or under-utilization of clinical resources
  - Quality oversight
  - Monitor for adherence to CMS, NCQA, State and health plan UM standards

For more information about Molina's UM program, or to obtain a copy of the HCS Program description, clinical criteria used for decision making, and how to contact a UM reviewer, access the Molina website or contact the UM department.

Medical Groups/IPAs and delegated entities who assume responsibility for UM must adhere to Molina's UM Policies. Their programs, policies and supporting documentation are reviewed by Molina at least annually.

UM Decisions

An organizational determination is any decision made by Molina or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination)
- Determination to delay, modify or deny authorization or payment of request (adverse determination)

Molina follows a hierarchy of medical necessity decision-making with federal and state regulations taking precedence. Molina covers all services and items required by state and federal regulations.
Board-certified licensed reviewers from appropriate specialty areas are utilized to assist in making determinations of medical necessity, as appropriate. All utilization determinations are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with federal and state regulatory requirements and NCQA standards.
Requests for authorization not meeting medical necessity criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician or

pharmacist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate may determine to delay, modify, or deny authorization of services to a member. Providers can contact Molina's Healthcare Services department at (855) 322-4078 to obtain Molina's UM Criteria.
Where applicable, Molina Clinical Policies can be found on the public website at MolinaClinicalPolicy.com. Please note that Molina follows state-specific criteria, if available, before applying Molina-specific criteria.

Medical Necessity

Medically Necessary means the care which, in the opinion of the treating physician, is reasonably needed to:

1. Prevent the onset or worsening of an illness, condition, or disability.
2. Establish a diagnosis.
3. Provide palliative, curative or restorative treatment for physical and/or mental health conditions.
4. Assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of same age.
5. Not primarily long-term institutional care services unless long-term institutional services are a Covered Service that the Provider has agreed to provide. In addition, there must be no other effective and more conservative or substantially less costly treatment, service and setting available.

Medically Necessary Services means clinical and rehabilitative physical, mental, or behavioral health services that are:

1. Essential to prevent, diagnose or treat medical conditions or are essential to enable the Member to attain, maintain or regain the Member's optimal functional capacity.
2. Delivered in the amount, duration, scope and setting that are both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical and behavioral health care needs of the Member.
3. Provided within professionally accepted standards of practice and national guidelines.
4. Required to meet the physical and behavioral health needs of the Member.
5. Not primarily for the convenience of the Member, the Provider or Molina.

This is for preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury, or disease; and,
3. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence

of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.
The fact that a Provider has prescribed, recommended, or approved medical or allied goods or services does not, by itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Molina has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity portal. With MCG Cite for Guideline Transparency, Molina can share clinical indications with Providers. The tool operates as a secure extension of Molina's existing MCG investment and helps meet regulations around transparency for delivery of care:

- Transparency—Delivers medical determination transparency.
- Access—Clinical evidence that payers use to support member care decisions.
- Security—Ensures easy and flexible access via secure web access.

MCG Cite for Guideline Transparency does not affect the process for notifying Molina of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.
Molina has also partnered with MCG Health to extend the Cite AutoAuth self-service method for all lines of business to submit advanced imaging prior authorization requests.
Cite AutoAuth can be accessed via the Availity portal and is available 24 hours per day/7 days per week. This method of submission is the primary submission route for advanced imaging requests. Molina will also be rolling out additional services throughout the year. Clinical information submitted with the PA will be reviewed by Molina. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.
What is Cite AutoAuth and how does it work?
By attaching the relevant care guideline content to each PA request and sending it directly to Molina, health care Providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.
Self-services available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs, PET scans. To see the full list of imaging codes that require PA, refer to the PA code Look-Up Tool at MolinaHealthcare.com.

Medical Necessity Review

Molina only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. To determine medical necessity, in conjunction with independent professional medical judgment, Molina uses nationally recognized evidence-based guidelines, third-party guidelines, CMS guidelines, State guidelines, Molina clinical policies, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

The Molina review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage. The Clinical review includes medical necessity and level of care.

All UM requests that may lead to a medical necessity adverse determination are reviewed by a health care professional at Molina (medical director, pharmacy director or appropriately licensed health care professional).

Molina's Provider training includes information on the UM processes and Authorization requirements.

Clinical Information

Molina requires copies of clinical information be submitted for documentation. Clinical information includes but is not limited to physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless state or federal regulations allow such documentation to be acceptable.

Prior Authorization

Molina requires prior authorization for specified services if it complies with federal or state regulations and the Provider Agreement with Molina. The list of services that require prior authorization is available in narrative form, along with a more detailed list by Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at MolinaHealthcare.com.

Providers are encouraged to use the Molina Prior Authorization Form provided on the Molina website. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina Member ID number).
- Provider demographic information (referring Provider and referred to Provider/facility including address and NPI number).
- Member diagnosis and International Classification of Diseases, 10th Revision (ICD-10) codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the medical necessity of the requested service is required including:
    - Pertinent medical history (including treatment, diagnostic tests, examination data).
    - Requested length of stay (for inpatient requests).
    - Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by federal and state law) are excluded from the prior authorization requirements. Obtaining authorization does not guarantee payment. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices, and whether the service was provided in the most appropriate and cost-effective setting of care. Molina does not retroactively authorize services that require prior authorization.

Molina follows all prior authorization requirements related to care for newborns and their mothers in alignment with the Newborns' and Mothers' Health Protection Act (NMHPA).
Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the standard time frame or decision-making process could seriously jeopardize the life or health of the Member, the health or safety of the Member or others, due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

Molina will make an organizational decision as promptly as the Member's health requires and no later than contractual and regulatory requirements. Expedited timeframes are followed when the Provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health.
Providers who request prior authorization for services and/or procedures may request to review the criteria used to make the final decision. A Molina full-time Medical Director is available to discuss Medical Necessity decisions with the requesting Provider at (855) 322-4078 during normal business hours.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone, fax, or via the Availity portal. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials are also communicated to the Provider via fax.

Peer-to-Peer Review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within 24 hours from a Provider's request, or at the Provider's first availability, for a peer-to-peer review at a mutually agreed upon time.

Peer-to-peer discussions can be requested as outlined below:

- P2P Scheduling Tool on Molina's website at MolinaHealthcare.com
- Email your requests to NM_HP_P2P_Scheduling@MolinaHealthcare.com.
- Contact our UM staff directly at (855) 322-4078

A "peer" is considered the Member's or Provider's clinical representative (licensed medical professional). Contracted external parties, administrators, or facility UM staff can only request that a peer-to-peer telephone communication be arranged and performed, but the discussion should be performed by a peer.

When requesting a peer-to-peer discussion, please be prepared with the following information:

- Member name and Molina Member ID number
- Authorization ID number
- Requesting Provider name and contact number and best times to call

If a Medical Director is not immediately available, the call will be returned within two (2) business days. Every effort will be made to return calls as expeditiously as possible.

Online peer-to-peer scheduling Tool

Providers may also use the online scheduling tool to request a Peer-to-Peer (P2P) Review. This tool is available to you for your Molina Medicaid patients for certain medical services. (The online P2P Scheduling Tool is currently only for Medicaid Medical P2P Review Requests, not Advanced Imaging, Behavioral Health, or Pharmacy.) Rather than calling Molina, providers can complete a simple online form to request a P2P Review. Link: MolinaHealthcare.com.

- You will receive a confirmation number at the time of submission.
- Molina will send you a confirmation email within 24 hours that includes the next steps.
- You may only submit one (1) request per Member.
- Please allow two (2) business days for Molina to respond.

Note: You may always request a Reconsideration instead of a P2P.

Important: Peer-to-peer calls are not recorded. Molina Medical Directors reserves the right to decline requests to record the peer-to-peer call. Any calls for a P2P discussion must be completed on a non-recorded line.

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement with Molina that requires Providers to obtain prior authorization directly from Molina, Molina may choose to contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the MolinaHealthcare.com website:

- Prior Authorization Code Look-up Tool
- Prior Authorization Code Matrix
- Prior Authorization Guide

The most current Prior Authorization Guidelines and the Prior Authorization Request Form can be found on the Molina website at MolinaHealthcare.com.

Availity portal**:** Participating Providers are encouraged to use the Availity portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Availity portal. The benefits of submitting your prior authorization request through the Availity portal are:

- Create and submit prior authorization requests
- Check status of prior authorization requests
- Receive notification of change in status of prior authorization requests.
- Attach medical documentation required for timely medical review and decision-making.

Fax: The Prior Authorization Request Form can be faxed to Molina. If the request is not on the form provided by Molina, be sure to send it to the attention of the Healthcare Services department. Please indicate in the fax if the request is urgent or non-urgent. The Definition of expedited/urgent is when the situation where the standard time frame or decision-making process could seriously jeopardize the life or health of the enrollee or could jeopardize the enrollee's ability to regain maximum function. Please include the supporting documentation needed for Molina to make a determination along with the request to facilitate your request being made as expeditiously as possible.

Authorizations & Inpatient Census	Availity portal: Provider.MolinaHealthcare.com
Physical Health	Fax: (833) 558-6769
Radiology	Fax: (877) 731-7218
NICU (Progeny Health)	Fax: (866) 484-6087
Transplant	Fax: (877) 813-1206
Pharmacy – Benefits, Medical Office Drugs, I.V. Infusion, TPN	Fax: (877) 731-7218

- Faxes received after 5 p.m., MT, Monday through Thursday will be considered received on the next business day.
- Faxes received after 5 p.m., MT, Friday or on Saturday or Sunday will be considered received on the next business day.
- Faxes received on a holiday will be considered on the next business day.

Toll-Free Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services department. It may be necessary to submit additional documentation before the authorization can be processed.

Prior Authorization forms and Services/Codes requiring prior authorization may be accessed below or on the Molina Provider website at MolinaHealthcare.com.

Authorizations & Inpatient Census	Availity portal: Provider.MolinaHealthcare.com
Physical Health	Phone: (855) 322-4078
Radiology	Phone: (855) 714-2415
NICU (Progeny Health)	Phone: (888) 832-2006
Transplant	Phone: (855) 714-2415
Pharmacy – Benefits, Medical Office Drugs, I.V. Infusion, TPN	Phone: (855) 322-4078

Medically Urgent Requests by toll-free phone: (855) 322-4078
All authorized services are subject to the Member's benefit plan and eligibility at the time the service is provided. Routine/Elective requests must be faxed to Molina.

The Prior Authorization/Pre-Service Review Guide and Form, and Codification Matrix are located on the Provider website at MolinaHealthcare.com.

Open Communication about Treatment

Molina prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with, and act as an advocate for their patients. Molina requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract. Molina and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a Member about the Member's health care. This includes treatment options, alternative plans or other coverage arrangements.

Delegated Utilization Management Functions

Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. They must have the ability to perform the delegated activities and maintain specific delegation criteria in compliance with all current Molina policies and regulatory and certification

requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the **Delegation** section of this Provider Manual.

Communication and Availability to Members and Providers

HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (855) 322-4078, Monday through Friday (except for state and federal holidays) from 8 a.m. to 5 p.m., MT. All staff Members identify themselves by providing their first name, job title and organization.
TTY/TDD services are available for Members who are deaf, hard of hearing or speech impaired. Language assistance is also always available for Members.
After business hours, Providers can also utilize fax and the Availity portal for UM access.
Molina's 24-Hour Nurse Advice Line is available to Members 24 hours a day, 7 days a week at (888) 275-8750 (English) or (866) 648-3537 (Spanish). Molina's 24-Hour Nurse Advice Line may handle after-hours UM calls.

Emergency Services

Emergency Services means: Covered Services that are inpatient or outpatient and are: (i) furnished by a Provider that is qualified to furnish these services; and (ii) needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition or Emergency means: a Physical Health or Behavioral Health condition manifesting itself through acute symptoms of sufficient severity (including nerve pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing the Member's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part; or
- serious disfigurement to the Member.

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent Emergency Services rendered to the Member do not require prior authorization from Molina.

Emergency services are covered on a 24-hour basis without the need for prior authorization for all Members experiencing an emergency medical condition.

Post-Stabilization Care Services are covered services that are:

1. Related to an Emergency Medical Condition;
2. Provided after the Member is stabilized; and
3. Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the Member's condition.

Providers requesting an in-patient admission as a post-stabilization service must request this type of service by contacting Molina toll-free at (855) 322-4078.
Inpatient admission requests (not including post-stabilization requests) received via fax will be processed within standard inpatient regulatory and contractual time frames.
Molina also provides Members with a 24-hour Nurse Advice Line for medical advice. The 911 information is given to all Members at the onset of any call to the plan.
For Members within our service area, Molina contracts with vendors that provide 24-hour Emergency Services for ambulances and hospitals. An out-of-network emergency hospital stay may only be covered until the Member has stabilized sufficiently to transfer to an available participating facility. Services provided after stabilization in a non-participating facility may not be covered and the Member may be responsible for payment.
Molina Care Managers will contact Members over-utilizing the emergency department to provide assistance whenever possible and determine the reason for using Emergency Services.

Care Coordinators will also contact the primary care provider (PCP) to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Planned Admissions

Molina requires prior authorization for all elective inpatient procedures to any facility. Facilities are required to notify Molina within 24 hours or by the following business day once an admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, medical necessity requirements or failure to include all the needed clinical documentation to support the need for an inpatient admission may result in a denial of authorization for the inpatient stay.

Inpatient at Time of Termination of Coverage

When a Member's coverage with Molina terminates during a hospital stay, Molina will continue to cover services through discharge unless Law or program requirements mandate otherwise.

Inpatient/Concurrent Review

Molina performs concurrent inpatient review to ensure the medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient

facilities. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within 24 hours of the request. Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.
Molina will authorize hospital care as an inpatient, when the clinical record supports the medical necessity for the need for continued hospital stay. It is the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge the Provider must provide Molina with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations

Molina's UM staff follow federal and state guidelines along with evidence-based criteria to determine if the collected clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and medical necessity requirements (refer to the **Medical Necessity Review** subsection of this Provider Manual).

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.
UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is an important part of Molina's Quality Improvement (QI) Program to ensure that Molina Members are receiving hospital care compliant with nationally recognized guidelines and federal and state regulations.
Molina will conduct readmission reviews when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.
When a subsequent admission to the same facility with the same or similar diagnosis occurs within (24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the readmission is related to the first admission and determined to be

preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

- A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:
  - Premature or inadequate discharge from the same hospital.
  - Issues with transition or coordination of care from the initial admission.
  - For an acute medical complication plausibly related to care that occurred during the initial admission.
- Readmissions that are excluded from consideration as preventable readmissions include:
  - Planned readmissions associated with major or metastatic malignancies, multiple traumas, and burns.
  - Neonatal and obstetrical readmissions.
  - Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed.
  - Behavioral Health readmissions.
  - Transplant related readmissions.

Post Service Review

Failure to obtain authorization when required may result in denial of payment for those services. The only possible exception for payment from the post-service review is if information is received indicating the Provider did not know or could have known that the patient was a Molina Member or there was a Molina error. In those cases, a Medical Necessity review will be performed. Decisions, in this circumstance, will be based on medical necessity.
Specific federal or state requirements or Provider contracts that prohibit administrative denials supersede this policy.

Affirmative Statement About Incentives

All medical decisions are coordinated and rendered by qualified practitioners and licensed staff unhindered by fiscal or administrative concerns. Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.
Molina requires that all utilization-related decisions regarding Member coverage and/or services are based solely on the appropriateness of care and existence of coverage. Molina does not specifically reward Practitioners or other individuals for issuing denials of coverage or care. Molina does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Out-of-Network Providers and Services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process to provide medical care to Molina Members. Molina requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services as defined by federal law. If there is a need to go

to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network Providers may provide Emergency Services for a Member temporarily outside the service area, without prior authorization or as required by federal or state laws or regulations.

Avoiding Conflict of Interest

The HCS department affirms its decision-making is based on the appropriateness of care and service and the existence of benefit coverage.
Molina does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization. Molina also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care and Services

Molina HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Molina's Integrated Care Coordination (ICC) program via assessment or referral such as, self-referral, Provider referral, etc. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end.
Molina staff provide an integrated approach to care needs by assisting Members with the identification of resources available to the Member, such as community programs, national support groups, appropriate specialists and facilities, identifying best practices or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members

Molina's policy is to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc., to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out-of-network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to 90 days or longer, if necessary, for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.

- High risk of second or third-trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer, if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Molina at (855) 322-4078.

Continuity and coordination of Provider communication

Molina stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is receiving, or in need of receiving, community care services by reason of mental or other disability, age or illness; and who is, or may be, unable to take care of themself, or unable to protect themself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents or nurses.
- Public or private school employees or childcare givers.
- Psychologists, social workers, family protection workers or family protection specialists.
- Attorneys, ministers or law enforcement officers.

Suspected abuse and/or neglect should be reported as follows:

Child Abuse

Pursuant to New Mexico law 32A-4-3, "Duty to Report Child Abuse and Child Neglect," every person who knows or has reasonable suspicion that a child is being abused or neglected in New Mexico must report the matter immediate to Children, Youth & Families Department, Law enforcement, or the appropriate tribal identity.

Licensed physicians, residents or interns, law enforcement officer, judges presiding during a proceeding, nurses, schoolteachers, school officials, social workers, and Members of the clergy who have information not privilege as a matter of law are mandated to report suspected child abuse.

Child Abuse can be reported to Children, Youth, and Family Department's (CYFD) statewide central intake child abuse hotline toll-free at (855) 333-SAFE [7233] or text SAFE from a cell phone, or to law enforcement or the appropriate tribal identity. Additional information

regarding Child Protective Services can be found at Children Youth and Family Department Central Abuse Line.

Adult Abuse

If you suspect an adult is being abused, neglected, or exploited, call Adult Protective Services. If you are a member of law enforcement, a medical clinic, fire department/fire rescue, or a financial institution, you may fax your completed report to Adult Protective Services Intake at (855) 414-4885.

Adult Abuse can be reported to the Adult Protective Services Toll-free Hotline at (866) 654-3219 or at (505) 476-4912. Additional information regarding Adult Protective Services can be found on their website at aging.nm.gov/about/contact.

Molina's HCS teams will work with PCPs and Medical Groups/IPAs and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities, or other clinical personnel. Under state and federal law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Molina will follow up with Members that are reported to have been abused, exploited, or neglected to ensure appropriate measures were taken, and follow up on safety issues. Molina will track, analyze and report aggregate information regarding abuse reporting to the Health Care Services Committee and the proper state agency.

PCP Responsibilities in Care Coordination Referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The care coordinator provides the PCP with the Member's Comprehensive Care Plan (CCP), interdisciplinary care team (ICT) updates, and information regarding the Member's progress through the CCP when requested by the PCP. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Care Coordinator Responsibilities

The Care Coordinator collaborates with the Member and any additional participants as directed by the Member to develop a CCP that includes recommended interventions from Member's ICT, as applicable. CCP interventions include the appropriate information to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the Care Coordinator and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the Care Coordinator:

- Assesses the Member to determine if the Member's needs warrant Care Coordination.

- Monitors and communicates the progress of the implemented CCP to the Member's ICT, as the Member's needs warrant.
- Serves as a coordinator and resource to the Members, their representative and ICT participants throughout the implementation of the CCP and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of CCP goals in order to determine an appropriate time for the Member's graduation from the ICC program.

Health Management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members. Level 1 Members can be engaged in the program for up to 90 days depending on Member preferences and the clinical judgement of the Health Management team.

Level 1 Health Management

Molina offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators that includes condition-specific triage assessment, care plan development and access to tailored educational materials. Members are identified via Health Risk Assessments and Identification and Stratification. You can also directly refer Members who may benefit from these program offerings. Members can request to be enrolled or disenrolled in these programs at any time. Molina My Health programs include:

- Molina My Health – Weight Management Program
- Molina My Health – Tobacco Cessation Program
- Molina My Health – Nutrition Consult Program

For more information about these programs or to refer a Member, please call toll-free at (833) 269-7830, or TTY/TDD at 711 Relay. You can also Fax a request to (800) 642-3691.

Maternity Screening and High-Risk Obstetrics

Molina offers to all pregnant Members prenatal health education with resource information as appropriate and screening services to identify high-risk pregnancy conditions. Care Coordinators with specialized OB training provide additional care coordination and health education for Members with identified high-risk pregnancies to assure best outcomes for Members and their newborns during pregnancy, delivery and through their sixth (6^{th}) week post-delivery. Pregnant Member outreach, screening, education, and Care Coordination are initiated by Provider notification to Molina, Member self-referral and internal Molina notification processes. Providers can notify Molina of pregnant Members via Fax using the Pregnancy Notification Report Form available at MolinaHealthcare.com.

Pregnancy Notification Process

The PCP shall submit to Molina the Pregnancy Notification Report Form (available at MolinaHealthcare.com) within one (1) working day of the first prenatal visit and/or positive pregnancy test.

Member Newsletters

Member Newsletters are posted on the MolinaHealthcare.com website at least once a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials

Members can access our easy-to-read evidenced-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression, and other relevant health topics identified during our engagement with Members. Materials are available through the Member Portal, direct mail as requested, email and the My Molina mobile app.

Program Eligibility Criteria and Referral Source

Health Management (HM) Programs are designed for Molina Members with a confirmed diagnosis. Identified Members will receive targeted outreach such as educational materials, telephonic outreach, or other materials to access information on their condition. Members can contact the Molina Member Services Contact Center at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which may include the following:

- Pharmacy claims data for all classifications of medications.
- Encounter Data or paid claims with a relevant CMS-accepted diagnosis or procedure code.
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry.
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members.
- External referrals from Provider(s), caregivers, or community-based organizations.
- Internal referrals from the 24-Hour Nurse Advice Line, Medication Management or Utilization Management.
- Member self-referral due to general plan promotion of programs through Member newsletters or other Member communications.

Provider Participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease
- Clinical resources such as patient assessment forms and diagnostic tools
- Patient education resources
- Provider Newsletters promoting the Health Management Programs, including how to enroll patients and outcomes of the programs
- Clinical Practice Guidelines
- Preventive Health Guidelines
- Case Management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on Health Management Programs is available from your local Molina Healthcare Services department.

Primary Care Providers

Molina provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina. Molina's Members are required to see a PCP who is part of the Molina Network. Molina's Members may select or change their PCP via the Molina Member Portal or by calling the Molina Member Services Contact Center at (844) 862-4543.

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a member to receive specialty services; however, no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral for services.
Molina will help to arrange specialty care outside the network when Providers are unavailable, or the network is inadequate to meet a member's medical needs. To obtain such assistance, contact the Molina UM department. Referrals to specialty care outside the network require prior authorization from Molina.

Care Coordination

Molina provides a comprehensive Care Coordination program to all Members who meet the criteria for services. The ICC program focuses on coordinating the care, services, and resources needed by Members throughout the continuum of care. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.
The Molina Care Coordinators may be licensed professionals and are educated, trained and experienced in Molina's ICC program. The ICC program is based on a Member advocacy

philosophy, designed and administered to ensure the Member's coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The ICC program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Molina Care Coordinator will complete an assessment with the member upon engagement after identification for ICC enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Care Coordinator is responsible for assessing the member's appropriateness for the ICC program and for notifying the PCP of ICC program enrollment, as well as facilitating and assisting with the development of the Member's CCP.

Referral to Care Coordination

Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider, themselves, caregiver, discharge planner or Molina Healthcare Services (HCS) to the ICC program. The Care Coordinator works collaboratively with the Members and all participants of the ICT when warranted, including the PCP and specialty Providers, ancillary Providers, the local Health Department, or other community-based resources when identified. The referral source should be prepared to provide the Care Coordinator with demographic, health care and social data about the referred Member.

Members with the following conditions may qualify for Care Coordination and should be referred to the Molina ICC Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic or end-stage medical conditions (e.g., neoplasm, organ/tissue transplants, End Stage Renal Disease)
- Comorbid chronic illnesses (e.g., asthma, diabetes, COPD, CHF, etc.)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing emergency department services inappropriately
- Children with Special Health Care Needs

Referrals to the ICC program may be made by contacting Molina at:
Toll-free Phone: (855) 322-4078

9. BEHAVIORAL HEALTH MEDICAL MANAGEMENT PROGRAM

Overview

Molina provides a behavioral health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty Providers to ensure whole person care. Molina complies with the most current Mental Health Parity and Addiction Equity Act requirements. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

Some behavioral health services may require prior authorization.

Behavioral health inpatient and residential services can be requested by submitting a prior authorization form or contacting Molina's prior authorization team at (855) 322-4078. Providers requesting after-hours authorization for these services should utilize the Availity portal or fax submission options.

Emergency psychiatric services do not require prior authorization. All requests for behavioral health services should include the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Molina utilizes standard, generally accepted medical necessity criteria for prior authorization reviews.

For additional information, please refer to the Prior Authorization subsection found in the **Health Care Services** section of this Provider Manual.

Access to Behavioral Health Providers and PCPs

Members may be referred to an in-network behavioral health Provider via referral from a PCP, medical specialist, or by Member self-referral. PCPs can screen and assess Members for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate behavioral health service within the scope of their practice. A formal referral form or prior authorization is not needed for a Member to self-refer or be referred to a PCP, specialist, or behavioral health provider. However, individual services provided by non-network behavioral health providers will require prior authorization.

Behavioral health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Members may be referred to a PCP and specialty care Providers to manage their health care needs. Behavioral health Providers may identify other health concerns, including physical health concerns, which should be addressed by referring the Member to a PCP.

Care Coordination and Continuity of Care

Discharge Planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up appointment scheduled with a Behavioral Health Provider prior to discharge and to occur within seven (7) days of the discharge date.

Interdisciplinary Care Coordination

In order to provide care for the whole person, Molina emphasizes the importance of collaboration amongst all Providers on the Member's treatment team in order to provide care for the whole person. Behavioral health, primary care and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase the communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunities for optimal health outcomes. Molina's Care Coordination program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

Care Coordination

Molina's Care Coordination team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and/or substance use disorder (SUD) needs. Members with high-risk psychiatric, medical, or psychosocial needs may be referred by a behavioral health professional or PCP to the ICC program.

Referrals to the ICC program may be made by contacting Molina at:

Toll-Free Phone: (855) 322-4078

For additional information on the ICC program please refer to the Care Coordination subsection found in the **Health Care Services** section of this Provider Manual.

Behavioral Health Crisis Line

Molina has a Behavioral Health Crisis Line that may be accessed by Members 24/7 year-round. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate support, resources and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling (844) 862-4543.

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support or anyone with concerns about someone else, can receive free and confidential support 24 hours a day, 7 days a week, 365 days per year by dialing 988 from any phone.

Behavioral Health Tool Kit for Providers

Molina has developed an online Behavioral Health Tool Kit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to behavioral health HEDIS® tip sheets and other evidence-based guidance, training opportunities for Providers and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both medical and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the "Health Resources" tab on New Mexico Providers Home Provider website.

Medical Necessity Definition

1. Medically necessary services are clinical and rehabilitative physical or behavioral health services that are:
    a. Essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible recipient to attain, maintain or regain functional capacity.
    b. Delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the eligible recipient.
    c. Provided within professionally accepted standards of practice and national guidelines.
    d. Required to meet the physical and behavioral health needs of the eligible recipient and are not primarily for the convenience of the eligible recipient, the Provider or the payer.
2. Application of the definition:
    a. A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by the Medical Assistance Division (MAD) or its designee.
    b. The department or its authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program's benefit package applicable to an eligible recipient will do so by:
        i. evaluating the eligible recipient's physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible recipient within their scope of practice, who have taken into consideration the eligible recipient's clinical history including the impact of previous treatment and service interventions and who have

consulted with other qualified health care professionals with applicable specialty training, as appropriate.

ii. considering the views and choices of the eligible recipient or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views.

iii. considering the services being provided concurrently by other service delivery systems.

c. Physical and behavioral health services will not be denied solely because the eligible recipient has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition.

d. Decisions regarding MAD benefit coverage for eligible recipients under 21 years of age will be governed by the EPSDT coverage rules.

e. Medically necessary service requirements apply to all medical assistance program rules.

Quality of Service Criteria

The following criteria are common to all levels of care for behavioral health conditions and substance use disorders. These criteria will be used in conjunction with criteria for specific levels of care.

1. The Member is eligible for benefits.
2. The Provider completes a thorough initial evaluation, including current assessment information.
3. The Member's condition and proposed services are covered under the terms of the benefit plan.
4. The Member's current condition can be most efficiently and effectively treated in the proposed level of care.
5. The Member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the Member's motivation have been made, or referrals to community resources or peer supports have been made.
6. There must be a reasonable expectation that essential and appropriate services will improve the Member's presenting problems within a reasonable period of time. "Improvement" in this context is measured by weighing the effectiveness of treatment against the evidence that the Member's condition will deteriorate if treatment is discontinued in the current level of care. Improvement must also be understood within the framework of the Member's broader recovery goals.
7. The goal of treatment is to improve the Member's presenting symptoms to the point that treatment in the current level of care is no longer required.

8. Treatment is not primarily for the purpose of providing respite for the family, increasing the Member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

9. The Member has provided informed consent to treatment. Informed consent includes the following:

    a. The Member has been informed of safe and effective alternatives.
    b. The Member understands the potential risks and benefits of treatment.
    c. The Member is willing and able to follow the treatment plan including the safety precautions for treatment.

10. The treatment/service plan stems from the Member's presenting condition and clearly documents realistic and measurable treatment goals as well as the treatments that will be used to achieve the goals of treatment. The treatment/service plan also considers the following:

    a. Use of treatments that are consistent with nationally recognized scientific evidence, prevailing medical standards for the treatment of the member's current condition and clinical guidelines.
    b. Significant variables such as the Member's age and level of development; the member's preferences, strengths, broader recovery goals and readiness for change; risks including barriers to care; past response to treatment; the Member's understanding of their condition, its treatment and self-care; and the role that the Member's family/social supports should play in treatment with the Member's permission.
    c. Interventions needed to address co-occurring behavioral health or medical conditions.
    d. Interventions that will promote the Member's participation in care, promote informed decision-making, and support the Member's broader recovery goals. Examples of such interventions are psychoeducation, motivational interviewing, recovery planning and use of an advance directive, as well as facilitating involvement with natural and cultural supports, and self-help or peer programs.
    e. Involvement of the Member's family/social supports in treatment and discharge planning with the Member's permission when such involvement is clinically indicated.
    f. How treatment will be coordinated with other behavioral health and medical Providers as well as within the school system, legal system and community agencies with the Member's permission.
    g. How the treatment plan will be altered as the Member's condition changes, or when the response to treatment is not as anticipated.

11. The discharge plan stems from the Member's response to treatment, and considers the following:

    a. Significant variables including the Member's preferences, strengths, broader recovery goals and readiness for change; risks including barriers to care; past

response to discharge; the Member's understanding of their condition, its treatment and self-care; and the role that the Member's family/social supports should play in treatment with the Member's permission.

b. The availability of a lower level of care, which can effectively and safely treat the Member's current clinical condition.
c. The availability of treatments, which are consistent with nationally recognized scientific evidence, prevailing medical standards for the treatment of the Member's current condition and clinical guidelines.
d. Involvement of the Member's family/social supports in discharge planning with the Member's permission when such involvement is clinically indicated.
e. Discharge will be coordinated with the Provider of post-discharge behavioral health care, medical Providers, as well as with the school system, legal system or community agencies with the Member's permission.

12. How the risk of relapse will be mitigated including:

a. Completing and accurate assessment of the Member's current level of function and ability to follow through on the agreed upon discharge plan.
b. Confirming that the Member has engaged in shared decision making about the discharge plan and that the Member understands and agrees with the discharge plan.
c. Scheduling a first appointment within seven (7) days of discharge when care at a lower level is planned.
d. Assisting the Member with overcoming barriers to care (e.g., a lack of transportation or childcare challenges).
e. Ensuring that the Member has an adequate supply of medication to bridge the time between discharge and the first scheduled follow-up psychiatric assessment.
f. Providing psychoeducation and motivational interviewing, assisting with recovery planning and use of an advance directive, and facilitating involvement with self-help and peer programs.
g. Confirming that the Member understands what to do in the event that there is a crisis prior to the first post-discharge appointment, or if the Member needs to resume services.

13. The availability of resources such natural and cultural supports, such as self-help and peer support programs, and peer-run services, which may augment treatment, facilitate the Member's transition from the current level of care, and support the Member's broader recovery goals.

Acute Inpatient Hospitalization

1. Definition of Service:

Acute Inpatient Psychiatric Hospitalization is a 24-hour secure and protected, medically staffed, psychiatrically supervised treatment service. This level of care is for stabilization

of urgent or emergent behavioral health problems. Acute Inpatient Hospitalization is provided specifically for those Members who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, are acutely and significantly disabled, or whose activities of daily living are significantly impaired. This level of care involves the highest level of skilled psychiatric services. It is rendered in a freestanding psychiatric hospital or the psychiatric unit of a general hospital. The care must be provided under the direction of an attending physician who performs a face-to-face interview of the Member within 24 hours of admission. The care involves an individualized treatment plan that is reviewed and revised frequently based on the Member's clinical status.

This level of care should not be authorized solely as a substitute for management within the adult corrections, juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system), or simply to serve as respite or housing.

This level of care is available for all age ranges, but admission should be to a unit that is age appropriate. For school age children and youth, academic schooling funded through the local school system or by the facility is expected.

2. Admission Criteria (Meets A and B, and C or D or E or F or G):

    a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 8.302.1.7 and the Member has a DSM diagnosed condition that requires, and is likely to benefit from, the proposed therapeutic intervention.
    b. Treatment cannot safely be administered in a less restrictive level of care.
    c. There is an indication of actual or potential imminent danger to self that cannot be controlled outside of a 24-hour treatment setting. Examples of indications include serious suicidal ideation or attempts, severe self-mutilation or other serious self-destructive actions.
    d. There is an indication of actual or potential imminent danger to others and the impulses to harm others cannot be controlled outside of a 24-hour treatment setting. An example of an indication includes a current threat and means to kill or injure someone.
    e. There is an indication of actual or potential grave passive neglect that cannot be treated outside of an acute 24-hour treatment setting.
    f. There is disordered thinking, psychomotor agitation, and/or a loss of impulse control or impairment in judgment leading to behaviors that place the Member or others in imminent danger. These behaviors cannot be controlled outside of a 24-hour treatment setting.
    g. There is a co-existing medical illness that complicates the psychiatric illness or treatment. Together the illnesses or treatment pose a high risk of harm for the Member and cannot be managed outside of a 24-hour treatment setting.

3. Continued Stay Criteria (Meets All):

a. The Member continues to meet admission criteria including the need for 24-hour medical supervision.
b. An individualized treatment plan that addresses the Member's specific symptoms and behaviors that required Inpatient treatment has been developed, implemented and updated, with the Member's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities.
c. The Member is making meaningful and measurable progress at the current level of care and/or the current or revised treatment plan can be reasonably expected to bring about significant improvements in the behaviors and/or symptoms leading to admission. Progress is documented toward treatment goals.
d. An individualized discharge plan has been developed, which includes specific time-limited, realistic, objective, and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.

4. Discharge Criteria (Meets All):

a. The Member has met their individualized discharge criteria.
b. The Member can be safely treated at a less intensive level of care.
c. An individualized discharge plan with appropriate, realistic and timely follow-up care has been formulated.

5. Exclusionary Criteria (May Meet Any):

a. The condition of primary clinical concern is one of a medical nature (not behavioral health) and, as outlined in the current Mixed Services Protocol, should be covered by another managed care entity.
b. The Member appears to have presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or inappropriate seeking of medications.

Days Awaiting Placement (DAP) Rate

1. Description:

Per NMAC 8.321.2.16 Inpatient Days Awaiting Placement (DAP) is a negotiated rate used when a Medicaid-eligible Member no longer meets acute care criteria, and it is verified that the eligible Member requires a residential level of care which may not be immediately located. Those days during which the eligible Member is awaiting placement to the lower level of care are termed DAP. These circumstances must be beyond the control of the inpatient Provider. **DAP is intended to be brief and to support transition to the lower level of care. DAP may not be used solely because the inpatient Provider did not pursue or implement a discharge plan in a timely manner.**

2. Approval Criteria (Must Meet All):

a. The Member is covered by Medicaid as administered by the Medical Assistance Division definition, and the Member has a DSM diagnosed condition that currently requires an acute inpatient psychiatric level of care.
b. The Member no longer meets continued stay criteria for inpatient acute psychiatric care and/or does meet discharge criteria, and there is a specific discharge plan in place to a residential level of care, but documented barriers to implementation of that plan exist that are beyond the control of the Provider or facility.
c. The Provider has made reasonable efforts to identify and obtain the services needed to implement the discharge plan and continues to actively work to identify resources to implement that plan.
d. Molina has authorized the residential level of care sought as the discharge, and documentation of this authorization has been made available to Molina utilization management personnel.

3. Exclusionary Criteria:

a. The Member has met their individualized discharge criteria and substantial barriers to discharge no longer exist.
b. The inpatient facility cannot demonstrate that it continues to actively work to eliminate barriers to the planned discharge.
c. The inpatient facility is pursuing a discharge to a level of care or service that a Molina psychiatrist peer reviewer has explicitly stated does not appear to meet admission criteria at this time.

23-Hour Observation Stay

This is not a level of care that requires prior authorization but is a level of care that is separate and distinct from psychiatric inpatient level of care.

1. Definition of Service:

A 23-hour Observation Stay occurs in a secure, medically staffed, psychiatrically supervised facility. This level of care, like acute inpatient hospitalization, involves the highest level of skilled psychiatric services. This service can be rendered in a psychiatric unit of a general hospital, or in the emergency department of a licensed hospital. The care must be provided under the direction of an attending physician who has performed a face-to-face evaluation of the Member. The care involves an individual treatment plan that includes access to the full spectrum of psychiatric services. A 23-hour Observation Stay provides an opportunity to evaluate Members whose needed level of care is not readily apparent. In addition, it may be used to stabilize a member in crisis, when it is anticipated that the Member's symptoms will resolve in less than 24 hours.
This level of care may be considered when support systems and/or a previously developed crisis plan have not sufficiently stabilized the Member, and the likelihood of further deterioration is high. This level of care is available for all age ranges.

If a physician orders an eligible recipient to remain in the hospital for less than 24 hours, the stay is not covered as inpatient admission but is classified as an observation stay. An observation stay is considered an outpatient service.

The following are exemptions to the general observation stay definition:

a. The eligible recipient dies.
b. Documentation in medical records indicates that the eligible recipient left against medical advice or was removed from the facility by their authorized representative against medical advice.
c. An eligible recipient is transferred to another facility to obtain necessary medical care unavailable at the transferring facility.
d. An inpatient admission results in the delivery of a child.

If an admission is considered an observation stay, the admitting hospital is notified that the services are not covered as an inpatient admission.

a. A hospital must bill these services as outpatient observation services.
b. Outpatient observation services must be medically necessary and must not involve premature discharge of an eligible recipient in an unstable medical condition.
c. The hospital or attending physician can request a re-review and reconsideration of the observation stay decision.
d. The observation stay review does not replace the review of one (1)- and two (2)-day stays for medical necessity.
e. Medically unnecessary admissions, regardless of length of stay, are not covered by benefits.

2. Admission Criteria (Meets A and B, and C or D or E):

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 8.302.1.7, and the Member has a DSM-diagnosed condition that requires, and is likely to benefit from, therapeutic intervention in less than 24 hours in a secure setting.
b. The Member cannot be evaluated in a less restrictive level of care.
c. The Member is expressing suicidal ideation or is expressing threats of harm to others that must be evaluated continuously for severity and lethality.
d. The Member has shown disruptive or dangerous behavior requiring further immediate observation and assessment. An evaluation of the etiology of such behaviors is needed, especially if suspected to be chemically or organically induced.
e. The Member presents with significant disturbances of emotions or thought processes that interfere with their judgment or behavior that could seriously endanger the Member or others if not evaluated and stabilized on an emergency basis.

3. Discharge Criteria (Meets Both):

a. The Member no longer meets admission criteria.
b. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

4. Exclusionary Criteria (May Meet Any):

a. The Member meets admission criteria for Acute Inpatient Hospitalization.
b. The Member appears to have presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or inappropriate seeking of medications.

Accredited Residential Treatment

Definition of Service

Accredited Residential Treatment Center (ARTC) Services are provided to Members under the age of 21 who, because of the severity or complexity of their behavioral health needs, require intensive behavioral health in a facility where they can be supervised and monitored by trained staff. These are Members who, as a result of a recognized psychiatric disorder(s), are a significant danger to themselves or others. ARTC facilities be supervised by the New Mexico Department of Children Youth & Family, Licensing and Credentialing Authority (or similar body when located in other states). The need for ARTC services must be identified in the Tot-to-Teen Healthcheck or other diagnostic evaluation furnished through a Healthcheck referral, and the Member must meet medical necessity criteria as part of EPSDT services [42 CFR Section 441.57].

ARTC services are provided 24 hours a day/7 days a week and are accredited by The Joint Commission (jointcommission.org/). ARTC's provide all diagnostic and therapeutic services and are medically always staffed with direct psychiatric services provided several days a week and with 24-hour psychiatric consultation availability. The services are, provided under the direction of an attending psychiatrist. The treatment plan is reviewed frequently and updated based on the Member's clinical status. Regular family therapy is a key element of treatment and is required except when clinically contraindicated. Discharge planning should begin at admission, including plans for successful reintegration into the home, school, and community. If discharge to a home/family may not be a realistic option, alternative placement/housing must be identified as soon as possible, and documentation of active efforts to secure such placement must be thorough.

This service should not be authorized solely as a substitute for management within the juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system) or simply to serve as respite or housing. Academic schooling funded through the local school system or by the facility is expected.

As discussed in NMAC 8.321.2.11 in addition to regularly scheduled structured counseling and therapy sessions (individual, group, family, or multifamily - based on individualized needs, and as specified in the treatment plan), ARTC also includes the facilitation of age-appropriate skills

development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management. ARTC also includes therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of recipients that are not primarily recreational or diversional in nature. Also, ARTC will not implement experimental or investigational procedures, technologies, non-drug therapies, or related services.

Admission Criteria (Meets All)

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.302.1.7, and the Member has a DSM-diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
b. The Member is experiencing emotional or behavioral problems in the home and/or community to such an extent that the safety or well-being of the Member or others is substantially at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu. A licensed behavioral health professional has assessed that the Member is likely to experience a deterioration of their condition to the point that inpatient hospitalization may be required if the individual is not treated at this level of care.
c. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the Member's needs. Documentation exists to support these contentions.

Continued Stay Criteria (Meets All)

a. The Member continues to meet admission criteria including the need for 24-hour staff supervision.
b. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the treatment goals. Progress is documented toward treatment goals.
c. The treatment and therapeutic goals are objective, measurable and time-limited to address the alleviation of psychiatric symptoms and precipitating psychosocial stressors.
d. An individualized discharge plan has been developed/updated, which includes specific realistic, objective, and measurable discharge criteria and plans for appropriate follow-up care within the Member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
e. An individualized discharge plan has been developed/ updated, including specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care within the Member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
f. The Member is actively participating in treatment and is motivated and engaged in activities that lead to the Member's discharge plan.
g. The Member's parent(s), guardian or custodian participates in the treatment and discharge planning. If parent (s), guardian or custodian are not involved, alternative natural supports need to be identified to engage in treatment and discharge planning.

h. Member is making progress in the treatment program. Goals are realistic, targeted, time-limited, and achievable.

Discharge Criteria (Meets All)

a. The Member has met their individualized discharge criteria.
b. The Member can be safely treated at a less intensive/restrictive level of care.
c. An individualized discharge plan linked to appropriate, realistic and timely follow-up care is in place.

Exclusionary Criteria For ARTC: (May Meet Any)

Evidence (documented) shows that the ARTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity has not been met.

a. There is evidence that the ARTC treatment episode is intended to defer or prolong a determination of a permanency plan. The unwillingness of a parent or guardian to receive the Member back into the home is not grounds for continued ARTC care.
b. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
c. Quality of Service Criteria # 5 has not been met: The Member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the Member's motivation have been made, or referrals to community resources or peer supports have been made.
d. Quality of Service Criteria # 8 has not been met: Treatment is not primarily for the purpose of providing respite for the family, increasing the Member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

Sub-Acute Residential Treatment

Not a Value-Added Service and is only available to Providers contracted specifically to provide this service.

Definition of Service

Sub-acute RTC is provided to Members under the age of 21 who, because of the severity or complexity of their behavioral health needs, and who require services beyond the scope of the usual Residential Treatment Center Services (RTC) milieu or other out-of-home or community-based treatment services. These are Members who, as a result of a recognized psychiatric disorder(s) are a significant danger to themselves or others, but not so acute as to need inpatient hospitalization. Sub-acute RTC facilities must be licensed by the New Mexico Department of Children, Youth & Family, Licensing and Credentialing Authority (or a similar body when located in other states). The need for RTC services must be identified in the Tot-to-Teen Healthcheck or other diagnostic evaluation furnished through a Healthcheck referral and

the Member must meet medical necessity criteria as part of EPSDT services [42 CFR Section 441.57].

Sub-Acute RTC services are provided 24-hours a day/7 days a week and are accredited by The Joint Commission (Jointcommission.org/). Sub-Acute RTC facilities provide all the diagnostic and therapeutic services provided by RTC, **but with a higher staff-to-client ratio**. Sub-Acute RTC units are medically staffed with direct psychiatric services provided seven (7) days a week and with 24-hour psychiatric consultation availability. The services are provided under an attending psychiatrist's direction. The treatment plan is reviewed frequently and updated based on the Member's clinical status. Regular family therapy is a key element of treatment and is required except when clinically contraindicated. Discharge planning should begin at admission, including plans for successful reintegration into the home, school, and community. If discharge to a home/family may not be a realistic option, alternative placement/housing must be identified as soon as possible, and documentation of active efforts to secure such placement must be thorough.

This service should not be authorized solely as a substitute for management within the juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system) or simply to serve as respite or housing. Academic schooling funded through the local school system or by the facility is expected.

As discussed in NMAC 8.321.2.11 in addition to regularly scheduled structured counseling and therapy sessions (individual, group, family, or multifamily - based on individualized needs, and as specified in the treatment plan), Sub-Acute RTC also includes the facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management. Sub-acute RTC also includes therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients that are not primarily recreational or diversional in nature. Also, Sub-Acute RTC will not implement experimental or investigational procedures, technologies, non-drug therapies, or related services.

Admission Criteria (Meets All)

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.302.1.7, and the Member has a DSM-diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
b. The Member is experiencing emotional or behavioral problems in the home and/or community to such an extent that the safety or well-being of the Member or others is substantially at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu. A licensed behavioral health professional has assessed that the Member is likely to experience a deterioration of their condition to the point that inpatient hospitalization may be required if the individual is not treated at this level of care.

c. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the Member's needs. Documentation exists to support these contentions.

Continued Stay Criteria (Meets All)

a. The Member continues to meet admission criteria including 24-hour staff supervision.
b. An individualized treatment plan that addresses the Member's specific symptoms and behaviors that require Sub-Acute RTC treatment has been developed, implemented and updated, with the Member's or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time limited.
c. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the treatment goals. Progress is documented toward treatment goals.
d. An individualized discharge plan has been developed/updated, which includes specific realistic, objective, and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
e. The Member is participating in treatment, or there are active efforts being made that can reasonably be expected to lead to the Member's engagement in treatment.

   The Member's parent(s), guardian or custodian is participating in the treatment and discharge planning, or persistent efforts are being made and documented to involve them, unless it is clinically contraindicated.

Discharge Criteria (Meets A or B, and C and D)

a. The Member has met their individualized discharge criteria.
b. The Member has not benefited from the Sub-Acute Residential Treatment Center.
c. Services despite documented persistent efforts to engage the Member.
d. The Member can be safely treated at a less intensive/restrictive level of care.

An individualized discharge plan with linkage to appropriate, realistic and timely follow-up care is in place.

Exclusionary Criteria for Sub-Acute RTC (May Meet Any)

a. There is evidence (documented) that the Sub-Acute RTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity has not been met. There is evidence that the Sub-Acute RTC treatment episode is intended to defer or prolong a permanency plan determination. The inability or unwillingness of a parent or guardian to receive the Member back into the home is not grounds for continued Sub-Acute RTC care.
b. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
c. The Member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the Member's

motivation have been made, or referrals to community resources or peer supports have been made.

d. Treatment is not primarily for the purpose of providing respite for the family, increasing the Member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

Residential Treatment Center Services

Definition of Service

Residential Treatment Center Services (RTC), as governed by NMAC 8.321.2.20 (nonaccredited RTC) are provided to Members under the age of 21 years who require 24-hour treatment and supervision in a safe therapeutic environment.

Non-Accredited Residential Treatment Centers and Group Homes

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients under 21 years of age who need the level of care furnished by psychosocial rehabilitation services in a residential setting, the New Mexico Medical Assistance Division (MAD) pays for services furnished in non-accredited residential treatment centers or group homes as part of EPSDT services [42 CFR § 441.57]. The need for non-accredited residential treatment centers and group home services must be identified in the Tot-to-Teen Healthcheck screen or other diagnostic evaluation through a health check referral. This section describes eligible Providers, covered services, service limitations, and general reimbursement methodology.

Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701(8.302.1), GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid when services are furnished and determine if Medicaid recipients have other health insurance.

Providers must maintain sufficient records to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701(8.302.1), GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of any financial resource collected or received by Provider on behalf of recipients, including federal or state governmental sources, and document receipt and disbursement of recipient funds.

Covered Services

Medicaid covers those medically necessary services for recipients under 21 years of age, which are designed to develop skills necessary for successful reintegration into the family or transition into the community. A level of care determination must indicate that the recipient needs the level of care furnished in non-accredited residential treatment centers or group homes.

Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment.

Centers must furnish the following services to receive reimbursement from Medicaid. Payment for the performance of these services is included in the center's reimbursement rate:

a. Performance of necessary evaluations and psychological testing for development of the treatment plan, while ensuring that evaluations already performed are not repeated.
b. Regularly scheduled structured counseling and therapy sessions for recipients, groups, families, or multifamily groups based on individualized needs, as specified in the treatment plan.
c. Facilitation of age-appropriate skills development in household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance, and money management.
d. Assistance to recipients in self-administration of medication in compliance with state policies and procedures.
e. Appropriate staff available on a 24-hour basis to respond to crises, determine the severity of the situation, stabilize recipients by providing support, make referrals, as necessary, and provide follow-up.
f. Consultation with other professionals or allied caregivers regarding a specific recipient.
g. Non-medical transportation services are needed to accomplish the treatment objective.
h. Therapeutic services to meet recipients' physical, social, cultural, recreational, health maintenance, and rehabilitation needs.

Non-covered Services

Services furnished by non-accredited treatment centers or group homes are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following specific activities furnished in non-accredited residential treatment centers or group homes:

a. Services not considered medically necessary for the condition of the recipients, as determined by MAD or its designee.
b. Room and board.
c. Services for which prior approval was not obtained.
d. Services furnished after the determination is made by MAD or its designee that the recipient no longer needs care.
e. Formal educational or vocational services related to traditional academic subjects or vocational training.
f. Experimental or investigations procedures, technologies, or non-drug therapies and related services.
g. Drugs classified as "ineffective" by FDA Drug Evaluations.
h. Activity therapy, group activities, and other services which are primarily recreational or diversional in nature.

Treatment Plan

An individualized treatment plan used in non-accredited residential treatment centers or group homes must be developed by a team of professionals in consultation with recipients, parents, authorized representatives, or others whose care recipients will be released after discharge.

The plan must be developed within 14 days of the recipient's admission.

a. The interdisciplinary team must review the treatment plan at least every 30 days.
b. The following must be contained in the treatment plan or documents used in developing the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:
    i. Statement of the nature of the specific problem and the specific needs of the recipient.
    ii. Description of the functional level of the recipient, including the following:
        - Mental status assessment
        - Intellectual function assessment
        - Psychological assessment
        - Educational assessment
        - Vocational assessment
        - Social assessment
        - Medication assessment
        - Physical assessment
    iii. Statement of the least restrictive conditions necessary to achieve the purposes of treatment.
    iv. Description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;
    v. Statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, which includes provisions for review and modification of the plan.
    vi. Specification of staff responsibilities, description of proposed staff involvement, and orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the recipient.
    vii. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected discharge date.

Admission Criteria (Meets All)

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the Member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
b. The Member is experiencing emotional or behavioral problems in the home, community and/or treatment setting to such an extent that the safety or well-being of the Member or others is at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu in a residential setting.

c. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of their condition to the point that a more restrictive treatment setting may be required if the individual is not treated at this level of care at this time.
d. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the Member's needs. Documentation exists to support these contentions.

Continued Stay Criteria (Meets All)

a. The Member continues to meet admission criteria including the need for 24-hour staff supervision.
b. An individualized treatment plan that addresses the Member's specific symptoms and behaviors that required Residential treatment has been developed, implemented, and updated, with the Member's or guardian's participation, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time limited.
c. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.
d. An individualized discharge plan has been developed which includes specific realistic, objective, and measurable discharge criteria and plans for appropriate follow-up care within the Member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been, or other barriers to discharge exist which the Provider has made reasonable efforts to mitigate.
e. The Member is actively participating in treatment and is motivated and engaged in active efforts to lead to the Member's discharge plan.
f. The Member's parent(s), guardian or/or custodian is participating in treatment and discharge planning. If parent(s), guardian, or custodian care are not involved, alternative natural supports need to be identified to engage in treatment and discharge planning. The criteria for this are weekly involvement in family therapy, treatment planning and discharge planning.
g. Member is making progress in the treatment program. Goals are realistic, targeted, time-limited, and achievable.

Discharge Criteria (Meets A or B, and C and D)

a. The Member has met their individualized discharge criteria.
b. The Member has not realized substantial benefit from Residential Treatment Services despite documented persistent efforts to engage the Member.
c. The Member can be safely treated at a less intensive/restrictive level of care.
d. An individualized discharge plan with linkage to appropriate, realistic and timely follow-up care is in place.

Exclusionary Criteria for RTC (May Meet Any)

a. There is evidence that the RTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity has not been met.
b. There is evidence that the RTC treatment episode is intended to defer or prolong a permanency plan determination. The inability or unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued RTC care.
c. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
d. The Member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the Member's motivation have been made, or referrals to community resources or peer supports have been made.
e. Treatment is not primarily for the purpose of providing respite for the family, increasing the Member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

Treatment Foster Care I and II

Definition of Service

Treatment Foster Care (TFC), as governed by NMAC 8.321.2.25 and NMAC 8.321.2.26 is a behavioral health service provided to Members under the age of 21 years who are placed in a 24-hour community-based supervised, trained, surrogate family through a TFC placement agency licensed by the New Mexico Department of Children Youth & Family, Licensing and Credentialing Authority.

NMAC citation 8.322.2/ MAD citation 745.1 TREATMENT FOSTER CARE Level I and Level II

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. The New Mexico Medical Assistance Division (MAD) pays for mental health services furnished to recipients under 21 years of age who have an identified need for treatment foster care and meet this level of care as part of EPSDT services [42 CFR § 441.57]. The need for treatment foster care services must be identified in the Tot-to-Teen HealthCheck or other diagnostic evaluation furnished through a HealthCheck referral. This section describes eligible Providers, covered services, service limitations, and general reimbursement methodology.

Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of any financial resource collected or received by

the Provider by behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.

Covered Services

Medicaid covers those services included in individualized treatment plans designed to help recipients develop skills necessary for successful reintegration into the natural family or transition into the community.

a. The family living experience is the core treatment service to which other individualized services can be added. Treatment foster parents are employed or contracted by the treatment foster care agency. Their responsibilities include:
   - Participation in the development of treatment plans for recipients by providing input based on their observations.
   - Assumption of primary responsibility for implementing the in-home treatment strategies specified in a treatment plan.
   - Recording information and documentation of activities, as required by the foster care agency and the standards under which it operates.
   - Helping recipients maintain contact with their families and enhancement of those relationships.
   - Supporting efforts specified by the treatment plan to meet the recipient's permanency planning goals.
   - Assisting recipients obtain medical, educational, vocational, and other services to reach goals identified in treatment plans.

b. The following services must be furnished by the agency certified for treatment foster care to receive reimbursement from Medicaid. Payment for performance of these services is included in the Provider's reimbursement rate:
   - Assessment of the recipient's progress in TFC and assessment of family interactions and stress.
   - Regularly scheduled counseling and therapy sessions for recipients in individual, family, or group sessions.
   - Facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques, and self-care techniques.
   - Crisis intervention, including 24-hour availability of appropriate staff to respond to crisis situations.
   - When a return to the natural family is planned, assessment of family strengths and needs and development of a family service plan.

Non-covered Services

Treatment foster care services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, **General Non-covered Services.**

Medicaid does not cover the following services:

- Room and Board
- Formal educational or vocational services related to traditional academic subjects or vocational training.
- Respite Care

Treatment Plan

The treatment plan must be developed by the treatment team in consultation with recipients, families or authorized representatives, physicians, if applicable, and others whose care recipients will be released after discharge. The plan must be developed within 14 days of a recipient's admission to the TFC program.

a. The treatment team must review the treatment plan every 30 days.
b. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:
    i. Statement of the nature of the specific problem and the specific needs of the recipient.
    ii. Description of the functional level of the recipient, including the following:
        - Mental status assessment
        - Intellectual function assessment
        - Psychological assessment
        - Educational assessment
        - Vocational assessment
        - Social assessment
        - Medication assessment
        - Physical assessment
    iii. Statement of the least restrictive conditions necessary to achieve the purposes of treatment.
    iv. Description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;
    v. Statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan.
    vi. Specification of staff and TFC parent responsibilities, description of proposed staff involvement, orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the recipient.
    vii. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected discharge date.

NMAC citation 322.5/ MAD citation 745.5 TREATMENT FOSTER CARE (LEVEL II)

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. The New Mexico Medical Assistance Division (MAD) pays for mental health services furnished to recipients under 21 years of age who have an identified need for treatment foster care and meet this level of care as part of EPSDT services [42 CFR § 441.57]. The need for treatment fosters care services must be identified in the Tot-to-Teen HealthCheck or other diagnostic evaluation furnished through a HealthCheck referral. This section describes eligible Providers, covered services, service limitations, and general reimbursement methodology. [11-1-99]

Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701 (8.302.1), GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section MAD-701 (8.302.1), GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of any financial resource collected or received by the Provider on behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds. [11-1-99]

Covered Services

Treatment Foster Care II is a mental and behavioral health treatment modality provided by a specially trained treatment foster care parent or family in their home. Treatment parents are employed by or contracted for and trained by a TFC agency certified by The New Mexico Children, Youth and Families Department (CYFD). TFC II combines the normalizing influence of family-based care with individualized treatment interventions and social supports, thereby creating a therapeutic environment in the family context or maintaining and extending an existing therapeutic context established in TFC. Through TFC II services, the child's symptoms are expected to decrease and functional level to improve or maintain so that they may be discharged successfully to a less restrictive setting that best meets the child's needs. Medicaid covers those services included in the individualized treatment plan designed to help recipients develop skills necessary for successful reintegration into the biological, foster or adoptive family or transition to the community. TFC II will allow for a step-down from TFC when the child improves and no longer meets those utilization review criteria. TFC II will also allow entry into the program at a lower level of care for those children who would benefit optimally from the treatment foster care model.

a. The therapeutic family living experience is the core treatment service to which other individualized services can be added. Treatment foster parents are employed or contracted by the treatment foster care agency. Their responsibilities include:
    i. Participation in developing treatment plans for recipients by providing input based on their observations.

ii. Assumption of primary responsibility for implementing the in-home treatment strategies as specified in an individualized treatment plan.
iii. Recording of information and documentation of all activities required by the foster care agency and the standards under which it operates.
iv. Helping recipients maintain contact with their families and fostering enhancement of those relationships as appropriate.
v. Supporting efforts specified by the treatment plan to meet the recipient's permanency planning goals.
vi. Through coordinating, linking and monitoring services, we assist recipients to obtain medical, educational, vocational, and other necessary services to reach goals identified in the treatment plan.

b. The following services must be performed by the agency or be contracted for and overseen by the agency certified for treatment foster care to receive reimbursement from Medicaid.
i. Assessment of the recipient and his biological, foster, or adoptive family's strengths and needs.
ii. Development of a discharge plan that includes a strength and needs assessment of the recipient's family when a return to that family is planned, including a family service plan.
iii. Development and monitoring of the treatment plan.
iv. Assessment of the recipient's progress in TFC II.
v. Assessment of the TFC II family's interaction with the recipient, their biological, foster, or adoptive family, and any stressors identified.
vi. Facilitation of age-appropriate skills development in the areas of household management, nutrition, physical, behavioral, and emotional health, basic life skills, social skills, time management, school and/or work attendance, money management, independent living skills, relaxation techniques, and self-care techniques.
vii. Ensuring the occurrence of counseling or therapy sessions for recipients in individual, family, and/or group sessions as specified in the treatment plan.
viii. Ensuring the availability of crisis intervention, including 24 hours a day, seven (7) days a week) availability of appropriately licensed parties to respond to crisis situations. [11-1-99]

Non-covered Services

Treatment foster care services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following services:

1. Room and Board
2. Formal educational or vocational services related to traditional academic subjects or vocational training.
3. Respite care. [11-1-99]

Treatment Plan

The treatment plan must be developed by the treatment team in consultation with the recipient, their biological, foster or adoptive family or authorized representative, physician(s), when applicable, and others in whose care the recipient is involved and/or in whose care to whom the recipient will be released after discharge. The plan must be developed within 14 days of a recipient's admission to the TFC II program.

a. The treatment coordinator must review the treatment plan every 30 days.
b. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:
    i. Statement of the nature of the specific problem and the specific needs and strengths of the recipient.
    ii. Description of the functional level of the recipient, including the following:
        1. Mental status assessment
        2. Intellectual function assessment
        3. Psychological assessment
        4. Educational assessment
        5. Vocational assessment
        6. Social assessment
        7. Medication assessment
        8. Physical assessment
    iii. Statement of the least restrictive conditions necessary to achieve the purposes of treatment.
    iv. Description of intermediate and long-range goals with the projected timetable for their attainment.
    v. Statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan.
    vi. Specification of staff and TFC II parent responsibilities and the description and frequency of the following components: proposed staff involvement, orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, special diet, and special procedures recommended for the health and safety of the recipient.
    vii. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge. [11-1-99]

Admission Criteria (Meets A, B, E, and C or D)

**These admission criteria are for both TFC I and II, with some caveats, as noted below.*

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the Member has a DSM

diagnosed condition that requires, and is likely to benefit from, therapeutic interventions implemented in a TFC/ family living experience treatment setting.

b. The Member's current (within 30 days of proposed admission) medical and psychiatric symptoms require and can be managed safely in a 24-hour supervised community/home-based setting.

c. The Member is immediately at risk for needing a higher level of services and/or being excluded from community, home or school activities due to clinically significant disruptive symptoms or behaviors. These symptoms or behaviors are not amenable to treatment in the Member's own home or a standard foster care environment.

d. A licensed behavioral health professional has made the assessment that the Member is likely to experience a deterioration of their condition to the point that a more restrictive treatment setting may be required if the individual is not treated at this level of care at this time.

e. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the Member's needs. Documentation exists to support these contentions.

For TFC I the following additional admission criteria must be met:

The Member is unable to participate independently (without 24-hour adult supervision) in age-appropriate activities.

For TFC II the following additional admission criteria must be met:

The Member has met the treatment goals of TFC I or is able to participate independently in age-appropriate activities without 24-hour adult supervision.

Additionally, to be appropriate for TFC II, the Member's treatment needs or social, behavioral, emotional, or functional impairments are not as serious or severe as those exhibited by Members who meet criteria for TFC I; therefore, services are less clinically intensive than those provided in TFC I. Members in TFC II can generally participate independently in age-appropriate activities (e.g., dressing self at age seven [7], working at age 16, attending school without parental classroom supervision), while Members in TFC I could require supervision for those activities. TFC II is often, but not always, used as a transition from TFC I; Members may be admitted directly to TFC II. Conversely, not all Members in TFC I need to go to TFC II before discharge from TFC.

Continued Stay Criteria (Meets All)

a. The Member continues to meet all relevant admission criteria.

b. The Member continues to need 24-hour adult supervision and/or assistance to develop, restore or maintain skills and behaviors necessary to live safely in their own home and community.

c. An individualized treatment plan that addresses the Member's specific symptoms and behaviors that required TFC treatment has been developed, implemented, and updated according to licensing rules, with the Member's and/or authorized representative's participation, which includes consideration of all applicable and appropriate treatment

modalities. The treatment and therapeutic goals are objective, measurable, and time-limited.

d. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.
e. An individualized discharge plan has been developed (and updated since the last clinical review/approval) which includes specific realistic, objective, and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
f. The Member is participating in treatment, or there are active, persistent efforts being made that can reasonably be expected to lead to the Member's engagement in treatment.
g. The parent, authorized representative, or custodian is participating in the treatment, discharge and/or permanency planning, or persistent efforts are being made and documented to involve them, unless it is clinically indicated otherwise.

Criteria for Transition from TFC I to TFC II (Meets All)

a. A review of the individualized treatment and permanency plan shows that the Member has met a significant portion of all TFC I treatment goals.
b. Continued stay in a treatment foster care setting is necessary to maintain the gains made in TFC I, but Member does not require the intensity of supervision associated with TFC I.
c. The Member is able to participate independently in age-appropriate activities without continuous adult supervision.

Discharge Criteria (Meets A or B, and C and D)

a. The Member has met their individualized discharge criteria.
b. The Member has not benefited from Treatment Foster Care despite documented persistent efforts to engage the Member.
c. The Member can be safely treated at a less intensive level of care.
d. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

Exclusionary Criteria for TFC I AND TFC II (May Meet Any)

a. There is evidence that the TFC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity has not been met.
b. There is evidence that the TFC treatment episode is intended to defer or prolong a permanency plan determination or is substituting for permanent housing.
c. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
d. Quality of Service Criteria: The Member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the Member's motivation have been made, or referrals to community resources or peer supports have been made.

e. Quality of Service Criteria Treatment is not primarily for the purpose of providing respite for the family, increasing the Member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

Group Home

1. Definition of Service

Group Home is a lower level of care than Residential Treatment Center Services and is indicated when a structured home-based living situation is unavailable or not clinically appropriate for the Member's behavioral health needs and the Member needs services focused on psychosocial skills development. Group Home services also differ from Treatment Foster Care in that they are residential and group-based rather than family and community-based.

NMAC citation 321.4 /MAD citation 742.3 NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS AND GROUP HOMES

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients under 21 years of age who need the level of care furnished by psychosocial rehabilitation services in a residential setting, the New Mexico Medical Assistance Division (MAD) pays for services furnished in non-accredited residential treatment centers or group homes as part of EPSDT services [42 CFR § 441.57]. The need for non-accredited residential treatment center and group home services must be identified in the Tot-to-Teen HealthCheck screen or other diagnostic evaluation furnished through a HealthCheck referral. This section describes eligible Providers, covered services, service limitations, and general reimbursement methodology.

Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES. Providers must maintain records documenting the source and amount of any financial resource collected or received by the Provider on behalf of recipients, including federal or state governmental sources and document receipt and disbursement of recipient funds.

Covered Services

Medicaid covers those medically necessary services for recipients under 21 years of age which are designed to develop skills necessary for successful reintegration into the family or transition into the community. A level of care determination must indicate that the recipient needs the level of care that is furnished in non-accredited residential treatment centers or group homes. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment. The following services must be furnished by centers to receive reimbursement from Medicaid. Payment for performance of these services is included in the center's reimbursement rate:

a. Performance of necessary evaluations and psychological testing for development of the treatment plan, while ensuring that evaluations already performed are not repeated.
b. Regularly scheduled structured counseling and therapy sessions for recipients, groups, families, or multifamily groups based on individualized needs, as specified in the treatment plan.
c. Facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance, and money management.
d. Assistance to recipients in self-administration of medication in compliance with state policies and procedures.
e. Appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize recipients by providing support, make referrals, as necessary, and provide follow-up.
f. Consultation with other professionals or allied caregivers regarding a specific recipient.
g. Non-medical transportation services are needed to accomplish the treatment objective.
h. Therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients.

Non-covered Services

Services furnished by non-accredited treatment centers or group homes are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following specific activities furnished in non-accredited residential treatment centers or group homes:

a. Services not considered medically necessary for the condition of the recipients, as determined by MAD or its designee.
b. Room and board.
c. Services for which prior approval was not obtained.
d. Services furnished after the determination is made by MAD or its designee that the recipient no longer needs care.

e. Formal educational or vocational services related to traditional academic subjects or vocational training.
f. Experimental or investigations procedures, technologies, or non-drug therapies and related services.
g. Drugs classified as “ineffective” by FDA Drug Evaluations.
h. Activity therapy, group activities, and other services which are primarily recreational or diversional in nature.

Treatment Plan

An individualized treatment plan used in non-accredited residential treatment centers or group homes must be developed by a team of professionals in consultation with recipients, parents, authorized representatives or others in whose care recipients will be released after discharge. The plan must be developed within 14 days of the recipient's admission.

a. The interdisciplinary team must review the treatment plan at least every 30 days.
b. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:
    i. Statement of the nature of the specific problem and the specific needs of the recipient.
    ii. Description of the functional level of the recipient, including the following:
        1. Mental status assessment
        2. Intellectual function assessment
        3. Psychological assessment
        4. Educational assessment
        5. Vocational assessment
        6. Social assessment
        7. Medication assessment
        8. Physical assessment
    iii. Statement of the least restrictive conditions necessary to achieve the purposes of treatment.
    iv. Description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of therapy services;
    v. Statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, which includes provisions for review and modification of the plan.
    vi. Specification of staff responsibilities, description of proposed staff involvement, and orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and

special procedures recommended for the health and safety of the recipient.

vii. Criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge, and projected date of discharge.

2. Admission Criteria (Meets A, B and C, and either D or E)

a. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.

b. The Member may manifest significant psychological or behavioral disturbances but can participate in age-appropriate community-based activities (including school) with assistance from group home staff or with other support.

c. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

d. A structured home-based living situation is unavailable or is not appropriate for the Member's needs.

e. The Member needs 24-hour therapeutic milieu but does not require the intensive staff assistance provided in Residential Treatment Center Services.

3. Continued Stay Criteria (Meets All)

a. The Member continues to meet admission criteria.

b. The Member still needs 24-hour supervision and assistance to develop or restore skills and behaviors necessary to live safely in the home and community.

c. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required group home treatment has been developed, implemented, and updated, with the Member's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable, and time-limited.

d. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.

e. An individualized discharge plan has been developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.

f. The Member is participating in treatment, or there are active, persistent efforts being made that can reasonably be expected to lead to the Member's engagement in treatment.

g. The parent, guardian or custodian is participating in the treatment, discharge and/or permanency planning, or persistent efforts are being made and documented to involve them, unless it is clinically indicated otherwise.

4. Discharge Criteria (Meets A or B, and C and D)

a. The Member has met their individualized discharge criteria.
b. The Member has not benefited from group home services despite documented persistent efforts to engage the Member.
c. The Member can be safely treated at a less intensive level of care.
d. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

5. Exclusionary Criteria (May Meet Any)

a. There is evidence that the group home placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity has not been met.
b. There is evidence that the group home treatment episode is intended to defer or prolong a permanency plan determination. The unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued group home care.
c. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.
d. MCO Quality of Service Criteria # 5 has not been met: The Member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the Member's motivation have been made, or referrals to community resources or peer supports have been made.
e. MCO Quality of Service Criteria # 8 has not been met: Treatment is not primarily for the purpose of providing respite for the family, increasing the Member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

Applied Behavior Analysis (ABA)

1. Definition of Service

ABA services are provided to a Medical Assistance Programs (MAP) eligible Member 12 months up to 21 years of age. A Member's eligibility for ABA service falls into one (1) of two (2) categories: "At Risk for Autism Spectrum Disorder (ASD)" or "Diagnosed with ASD." An eligible Member must meet the level of care (LOC) Criteria detailed below, which includes medically necessary criteria.

Medically Necessary Services

a. Medically necessary services are clinical and rehabilitative physical or behavioral health services that:
    i. are essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible Member to attain, maintain or regain functional capacity.

ii. are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the eligible Member.
iii. are provided within professionally accepted standards of practice and national guidelines.
iv. are required to meet the physical and behavioral health needs of the eligible Member and are not primarily for the convenience of the eligible Member, the Provider or the payer.

b. Application of the definition:
i. A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by MAD or its designee.
ii. The department or its authorized agent making the determination of the medical necessity of clinical, rehabilitative, and supportive services consistent with the specific program's benefit package applicable to an eligible Member will do so by:
1. evaluating the eligible Member's physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible Member within their scope of practice, who have taken into consideration the eligible Member's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate.
2. considering the views and choices of the eligible Member or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views.
iii. considering the services being provided concurrently by other service delivery systems.
iv. Physical and behavioral health services will not be denied solely because the eligible Member has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration, or scope to an otherwise eligible Member solely because of the diagnosis, type of illness or condition
v. Decisions regarding MAD benefit coverage for eligible Members under 21 years of age will be governed by the EPSDT coverage rules.
vi. Medically necessary service requirements apply to all medical assistance program rules.

2. Admission Criteria for Diagnosed with ASD and At-Risk for ASD (Must meet AG for admission)

a. Services are determined to be medically necessary per NMAC 8.302.1.7.

b. The eligible Member cannot adequately participate in home, school, or community activities because the presence of behavioral excesses (i.e., socially significant behaviors) and/or the absence of functional skills interfere with meaningful participation in these activities.
c. The eligible Member presents a safety risk to self or others. (The presence of safety risk to self or others does not need to meet the threshold criteria for out-of-home placement.)
d. There is a reasonable expectation that ABA services will result in measurable improvement in the acquisition of functional, adaptive skills, and/or the reduction of non-functional, maladaptive behavior.
e. The eligible Member's caregivers are able to participate and commit meaningfully to ABA interventions and activities to be conducted outside the formal treatment environment.
f. The eligible Member follows the prescribed three (3)-stage comprehensive approach to evaluation, assessment, and treatment as outlined in the MAD ABA Billing Instructions.
g. The eligible Member meets one of the following two (2) categories:
    1. At-risk for ASD: A Member may be considered At-Risk for ASD, and therefore eligible for time-limited, Focused ABA Services if they do not meet full criteria for ASD per the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), and when they meet all of the following criteria:
        i. Is between 12 and 36 months of age.
        ii. Presents with developmental differences and/or delays as measured by standardized assessment.
        iii. Demonstrates some characteristics of the disorder (e.g., impairment in social communication and early indicators for the development of restricted and repetitive behavior).
        iv. Presents with at least one (1) genetic risk factor (e.g., the eligible Member has genetic risk due to having an older sibling with a well-documented medical diagnosis of ASD; the eligible Member has a diagnosis of Fragile X syndrome).
    2. Diagnosed with ASD: An eligible Member 12 months up to 21 years of age who has a medical diagnosis of ASD according to the latest DSM or ICD criteria is eligible for ABA services if the evaluation leading up to a diagnosis of ASD meets service requirements as stated in NMAC 8.321.2 (10.C) Covered services - stage 1.
    3. When a Member has been diagnosed with ASD within the last 12 months by an in-state or out-of-state Provider who meets Stage 1 Provider requirements, an ICD may be developed.

3. Continued Eligibility Criteria (Must meet A through C, or both A and D for continuation)

a. The eligible Member continues to meet the ABA admission criteria.
b. There is evidence that the child, family, and social support can continue to participate effectively in this service.
c. The eligible Member responds positively to ABA services, as evidenced by quantitative data submitted by the ABA Provider (AP) when requesting prior authorization for continuation of ABA services.
d. When the eligible Member does not respond positively to ABA services, as evidenced by quantitative data and clinical information submitted by the ABA Provider (AP) when requesting prior authorization for continuation of ABA services, the treatment plan and the treatment plan report (i.e., graphs, peer review) must be updated to reflect what interventions will be changed to produce measurable gains.

4. Discharge Criteria (Must meet one of A-D for discharge)

Individualized discharge criteria are developed with appropriate, realistic, and timely follow-up care and these criteria are included in the initial or most current ABA Treatment Plan. An eligible member may be discharged from ABA services when any of the following are present:

a. The eligible Member has met his or her individualized discharge criteria.
b. The eligible Member has reached the defining age limit as specified for At-Risk for ASD eligibility, which is up to three (3) years of age, or diagnosed with ASD eligibility which is under 21 years of age.
c. The eligible Member can be appropriately treated at a less intensive level of care.
d. The eligible Member requires a higher level of care, which includes out-of-home placement.

Note: Out-of-home placement would not include treatment foster care because ABA services could continue at that level of care.

5. Exclusionary Criteria (Must meet one of A-F for exclusion)

An eligible Member may be excluded from ABA services when any of the following are present:

1. The eligible Member's Comprehensive or Targeted Diagnostic Evaluation or the ISP and/or Treatment Plan Updates recommend placement in a higher, more intensive, or more restrictive LOC (Not to include treatment foster care: See note in Section III).
2. The eligible Member's Provider, such as psychiatrist, recommends higher LOC.
3. The eligible Member is in an out-of-home placement (Not to include treatment foster care: See note in Section III). An exception is that time limited ABA services may be authorized while the Member remains in the out-of-home facility for transition when ABA services are approved to be rendered upon their discharge from the facility to a community ABA Provider.

4. The referral for the Comprehensive Diagnostic Evaluation did not follow the eligibility requirements defined in 8.321.2 Section 10(B).
5. The Member has reached the maximum age for ABA services.
6. Family/caregiver is unable to participate in the treatment plan.

Value-Added Services

The following services/benefits are offered by Molina and are not mandatory covered services.

1. Electroconvulsive Therapy (ECT)

A. Service Description:

For use as a treatment for severe depression that has not responded to other treatment. Short-term ECT is given for a limited number of times per week for a limited number of weeks. Maintenance ECT is provided as required; maintenance ECT is provided less frequently than short-term ECT, i.e., once per week/two (2) weeks/month. Short-term ECT & Maintenance ECT is typically for adults but will evaluate pediatric population on a case-by-case basis.

B. Criteria for Approval (Must meet all):

i. Medical necessity has been demonstrated according to the member's clinical needs, and the Member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.
ii. A second opinion from a psychiatrist confirms that ECT is an appropriate treatment for the Member.
iii. A medical evaluation indicates no contraindication for ECT.
iv. Informed consent for ECT has been obtained and documented in the treatment record.
v. The Member has treatment resistant depression or psychotic disorder, is experiencing a severe or prolonged manic episode unresponsive to usual treatments, cannot tolerate usual psychotropic medications, exhibits food refusal leading to nutritional compromise or is experiencing such intense suicidal ideation that there is an urgent need for response, or it is the Member's choice for treatment.

C. Criteria for Maintenance Electroconvulsive Therapy (Must Meet All):

i. The Member meets the criteria for approval for ECT as outlined above, received ECT, and had a positive response.
ii. Other treatment options are not viable for the Member.
iii. A second opinion from another (other than the current treating psychiatrist) is obtained every six (6) months documenting the need for maintenance ECT.

Infant Mental Health (IMH)

1. Service Description:

Infant Mental Health Services (IMH) target children (0-5) in distress or with clear symptoms indicating a mental health disorder. IMH addresses problems with attachment and relationships in families, focuses on the parent-child relationship, and are designed to improve infant and family functioning to reduce the risk for more severe behavioral, social, emotional, and relationship disturbances as infants get older. IMH provides relationship-focused interventions to the parents, foster parents, or other primary caregivers with infants and toddlers.

2. Criteria for Approval ((Must Meet All):

A. Before engaging in IMH Treatment Services, the infant must have a comprehensive treatment file containing the following:
   i. One infant mental health diagnostic evaluation.
   ii. One individualized service plan that includes IMH Treatment Services as an intervention.

B. At least 80% of IMH services need to be provided in vivo in the home or other settings natural to the infant and family.

C. Infant/parent psychotherapy must be provided by an endorsed level 3 or 4 infant mental health specialist.

D. In addition, Providers of this service must have the capacity to:
   i. Coordinate with other children's serving systems to address the infant and caregiver's concrete, developmental and environmental needs; and,
   ii. Provide guidance to parents/caregivers with information and strategies that address an infant's social and emotional capacities, as well as parental/caregiver strengths.

10. PHARMACY

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our Members with high-quality, cost-effective drug therapy. Molina works with our Providers to ensure medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain over-the-counter drugs.

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T Committee is organized to assist Molina with managing pharmacy resources and to improve the overall satisfaction of Molina Members and Providers. It seeks to ensure Molina Members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee voting members consists of external physicians and pharmacists from various clinical specialties.

Pharmacy Network

Members must use their Molina Member ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations and network pharmacies is available by visiting MolinaHealthcare.com or calling Molina at (855) 322-4078.

Drug Formulary

Molina keeps a list of drugs, devices and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescription and over-the-counter products Members can get from a pharmacy. Some prescription medications require prior authorization or have limitations on age, dosage and/or quantities. For a complete list of covered medications please visit MolinaHealthcare.com.

Information on procedures to obtain these medications is described within this Provider Manual and also available on the Molina website at MolinaHealthcare.com.

Formulary Medications

Formulary medications with prior authorization may require the use of first-line medications before they are approved. Information on procedures to obtain these medications is described within this Provider Manual and is also available on the Molina website at MolinaHealthcare.com.

Quantity Limitations

In some cases, Members may only be able to receive certain quantities of medication. Information on specific limits can be found in the formulary document. Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Step Therapy

Plan restrictions for certain Formulary drugs may require that other drugs be tried first. The Formulary designates drugs that may process under the pharmacy benefit without prior authorization if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers are not considered as meeting step therapy requirements or as justification for exception request.

Non-Formulary Medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a prior authorization form which is available on the Molina website at MolinaHealthcare.com. Clinical evidence must be provided and taken into account when evaluating the request to determine medical necessity. The use of manufacturer samples of non-formulary or prior authorization required medications does not override formulary requirements.

Generic Substitution

Generic drugs should be dispensed when preferred. If the use of a particular brand name non-preferred drug becomes medically necessary as determined by the Provider, prior authorization must be obtained through the standard prior authorization process.

New-to-Market Drugs

Newly approved drug products will not normally be placed on the formulary during their first six (6) months on the market. During this period, access to these medications will be considered through the prior authorization process.

Medications Not Covered

There are some medications that are excluded from coverage. For example, drugs used in the treatment of fertility, experimental drugs, or those used for cosmetic purposes are not part of the benefit. For a complete list of drugs excluded from the plan benefit please refer to the formulary document on Molina's website at MolinaHealthcare.com.

Submitting a Prior Authorization Request

Molina will only process completed prior authorization request forms if the following information is included:

- Member first name, last name, date of birth and Molina Member ID number
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity and directions of use
- Diagnosis

Molina's decisions are based upon the information included with the prior authorization request. Clinical notes are recommended. If clinical information and/or medical justification is missing Molina will either fax or call your office to request clinical information to complete the review. To avoid delays in decisions, be sure to complete the prior authorization form in its entirety, including medical justification and/or supporting clinical notes.
Fax a completed Medication Prior Authorization Request Form to Molina at (877) 731-7218. A blank Medication Prior Authorization Request Form may be obtained at MolinaHealthcare.com or by calling Molina at (855) 322-4078.
Providers and office staff can review Molina Clinical Criteria and Clinical Policies online to ensure all required information is submitted for review.

Member and Provider Patient Safety Notifications

Molina has a process to notify Members and Providers regarding a variety of safety issues which include voluntary recalls, FDA-required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA-accredited organization.

Specialty Pharmaceuticals, Injectable and Infusion Services

Many specialty medications are covered by Molina through the pharmacy benefit using National Drug Codes (NDC) for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications may be covered through the medical benefit using Healthcare Common Procedure Coding System (HCPCS) via electronic medical claim submission. During the utilization management review process, Molina will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any federal or state regulatory requirements and the Member's specific benefit plan coverage prior to determination of benefit processing.

Molina may conduct a peer-to-peer discussion or other outreach to evaluate the level of care that is medically necessary. If an alternate site of care is suitable, Molina may offer the ordering Provider help in identifying an in-network infusion center, physician office or home infusion service and will help the Member coordinate and transition through case management.
If it is determined to be a pharmacy benefit, Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to the Provider's office or the Member's home. All packages are individually marked for each Member and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact Molina's Provider Relations Representatives with any further questions about the program.
Newly FDA-approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina P&T committee. "Buy-and-bill" drugs are pharmaceuticals which a Provider purchases and administers and for which the Provider submits a medical claim including the drug NDC to Molina for reimbursement.
Molina clinical services completes utilization management for certain healthcare administered drugs. Any drugs on the prior authorization list that use a temporary C code or other temporary HCPCS code that is not unique to a specific drug, which are later assigned a new HCPCS code, will still require prior authorization for such drug even after it has been assigned a new HCPCS code, until otherwise noted in the prior authorization list.

Non-Formulary Requests for Specialty/Injectable Medication

Specialty/injectable medications generally require prior authorization or are managed in terms of the number of doses allowed in a certain time span. When requesting prior authorization for injectable medications, complete a copy of the New Mexico Universal Drug Prior Authorization Request Form at MolinaHealthcare.com and fax it to Molina Healthcare Pharmacy Management Department at toll-free fax number at (833) 896-0519. Please include all pertinent medical necessity documentation that justifies the use of a non-formulary medication as well as the expected duration of therapy. Molina will review the request and evaluate it according to established guidelines. The resulting decision will be communicated to both the prescriber and the Member.
Approved injections supplied by and administered in a practitioner's office should be billed electronically or on a CMS-1500 form.

Non-Formulary Requests for Oral Medications

Complete the New Mexico Uniform Prior Authorization Form and fax it to the Molina Healthcare Pharmacy Management Department at the toll-free fax number (833) 896-0519. Please include all pertinent medical necessity documentation that justifies the use of a non-formulary medication and the expected duration of therapy. Molina will review and evaluate it according to established guidelines. The resulting decision will be communicated to both the prescriber and the Member.

Formulary Addition Requests from Practitioners

We value and want your feedback. Molina convenes a Pharmacy and Therapeutics (P&T) Committee to review formulary changes. The committee is composed of Molina staff and actively practicing, contracted physicians of various specialties and pharmacists.

To request a formulary addition, please download the request form at this link – Formulary Addition Request Form. Please fax the request form toll-free to (833) 896-0519. The P&T Committee will review the request as soon as possible and communicate its decision to the requesting practitioner.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding opioid and pain safety as needed.
Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional opioid-safety and substance use disorder resources at MolinaHealthcare.com under the Health Resource tab. Please consult with your Provider Relations Representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

11. CREDENTIALING

The purpose of the Credentialing Program is to assure that Molina Healthcare and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure, which can be requested by contacting Molina Provider Relations Representatives.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

The Credentialing Program has been developed in accordance with state and federal requirements and the standards of the National Committee for Quality Assurance (NCQA).

The Credentialing Program is reviewed annually, revised, and updated as needed.

Non-Discriminatory Credentialing and Recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status or patient types (e.g., Medicaid) in which the Practitioner specializes. This does not preclude Molina from including in its network Practitioners who meet certain demographic or specialty needs (e.g., to meet the cultural needs of Members).

Types of Practitioners Credentialed & Recredentialed

Practitioners and groups of Practitioners with whom Molina contracts must be credentialed prior to the contract being implemented. Molina will conduct background checks which includes verification of sanctions prohibiting participation with government programs.

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care practitioners who are licensed, certified or registered by the State to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's-level psychologists
- Licensed/Certified Midwives (Non-Nurse)

- Massage Therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioners

Criteria for Participation in the Molina Network

Molina has established criteria, and the sources used to verify these criteria for the evaluation and selection of Practitioners for participation in the Molina network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Practitioners who do not meet the criteria. Molina may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any practitioner to a hearing or any other right of review.

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Molina network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete, and it will result in an administrative denial or termination from the

Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application** – Practitioners must submit to Molina a complete credentialing application either from CAQH ProView or other State-mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, Certification or Registration** – Practitioners must hold a current and valid license, certification, or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are required to be licensed in the State where they are located, and the State the Member is located.
- **Drug Enforcement Administration (DEA) Certificate** – Practitioners must hold a current, valid, unrestricted DEA certificate. Practitioners must have a DEA certificate in every State where the Practitioner provides care to Molina Members. If a Practitioner has a pending DEA certificate and never had any disciplinary action taken related to their DEA certificate or chooses not to have a DEA certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number.
- **Controlled Dangerous Substances (CDS) Certificate** – Practitioners must hold a current, valid CDS certificate. Practitioners working from AZ, OK or UT practice locations must meet CDS requirements in those states.
- **Specialty** – Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education** – Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency training** – Practitioners must have satisfactorily completed residency training from an accredited program in the specialties in which they are practicing. Molina only recognizes programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) in the United States, the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three (3) years. If the podiatrist has not completed a three (3)-year residency or is not board-certified, the podiatrist must have five (5) years of work history practicing podiatry.
- **Fellowship training** – Fellowship training is verified when a practitioner is advertised in the directory in their fellowship specialty. Molina only recognizes fellowship programs accredited by ACGME, AOA, CFPC and CODA.

- **Board certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed residency training from an accredited program in the specialty in which they are practicing. Molina recognizes certification only from the following Boards:
  - American Board of Medical Specialties (ABMS)
  - American Osteopathic Association (AOA)
  - American Board of Foot and Ankle Surgery (ABFAS)
  - American Board of Podiatric Medicine (ABPM)
  - American Board of Oral and Maxillofacial Surgery
  - American Board of Addiction Medicine (ABAM)
  - College of Family Physicians of Canada (CFPC)
  - Royal College of Physicians and Surgeons of Canada (RCPSC)
  - Behavioral Analyst Certification Board (BACB)
  - National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners** – Practitioners who are not board certified and have not completed training from an accredited program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five (5) years without any gaps in work history. Molina will consider allowing a Practitioner who is/was board certified and/or residency-trained in a specialty other than primary care to participate as a General Practitioner if the Practitioner is applying to participate as a Primary Care Physician (PCP) or as an Urgent Care or Wound Care Practitioner. General Practitioners providing only wound care services do not require five (5) years of work history as a PCP.
- **Nurse Practitioners & Physician Assistants** – In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, the Practitioner providing the supervision and/or oversight must also be contracted and credentialed with Molina.
- **Work history** – Practitioners must supply the most recent five (5) years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) months, the Practitioner must clarify the gap verbally or in writing. The organization will document a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, the Practitioner must clarify the gap in writing.
- **Malpractice history** – Practitioners must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioners must disclose a full history of all license/certification/registration actions, including denials, revocations, terminations, suspension, restrictions, reductions,

limitations, sanctions, probations, and non-renewals. Practitioners must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failing to proceed with an application to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At the time of initial application, the Practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body[25]. This would include Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent.

- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioners must not be currently sanctioned, excluded, expelled, or suspended from any State or Federally funded program, including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt-Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number, which should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioners activities on Molina's behalf. Practitioners maintaining coverage under Federal tort or self-insured policies are not required to include amounts of coverage in their application for professional or medical malpractice insurance.
- **Inability to Perform** – Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable

[25] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.

- **Lack of Present Illegal Drug Use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions** – Practitioners must disclose if they have ever had any of the following:
  - Criminal convictions including any convictions, guilty pleas, or adjudicated pretrial diversions for crimes against person such as murder, rape, assault and other similar crimes.
  - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
  - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
  - Any crime that would result in mandatory exclusion under Section 1128 of the Social Security Act.
  - Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances, or similar crimes.

  At the time of initial credentialing, Practitioners must not have any pending criminal charges in the categories listed above.
- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioners must have a National Provider Identifier (NPI) issued by the Centers for Medicare & Medicaid Services (CMS).

Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

Molina will notify the Practitioner immediately if credentialing information obtained from other sources varies substantially from that submitted by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification actions, sanctions, or exclusions. Molina is not required to reveal the source of information if the

information is obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner rights are published on the Molina website and are included in this Provider Manual.

The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

- Their requirement to submit a written response within 10 calendar days of receiving notification from Molina.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information, and may provide any proof that is available.
- The Practitioner's response must be sent to:

  Molina Healthcare, Inc.
  Attention: Credentialing Director
  PO Box 2470
  Spokane, WA 99210

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

If the Practitioner does not respond within 10 calendar days, their application processing will be discontinued, and network participation will be administratively denied or terminated.

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner rights are published on the Molina website and are included in this Provider Manual.

The Practitioner must notify the Credentialing department and request an appointment time to review their file and allow up to seven (7) calendar days to coordinate schedules. The Medical Director, a Director responsible for Credentialing or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the Practitioner are documents which the Practitioner sent to Molina (e.g., the application and any other attachments submitted with the

application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

Practitioners have the right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner rights are published on the Molina website and are included in this Provider Manual. Molina will respond to the request within two (2) working days. Molina will share with the Practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

Professional Review Committee (PRC)

Molina designates a PRC to make recommendations regarding credentialing decisions using a peer review process. Molina works with the PRC to assure that network Practitioners are competent and qualified to provide continuous quality care to Molina Members. The PRC reports to the Quality Improvement Committee (QIC). Molina utilizes information such as, but not limited to credentialing verifications, QOCs, and member complaints to determine continued participation in Molina's network or if any adverse actions will be taken. Certain PRC decisions may be appealed. To utilize this process, providers should request a fair hearing as outlined below and in Molina's policy. Please contact Molina Provider Relations Representatives for additional information about fair hearings.

Notification of Credentialing Decisions

A letter is sent to every Practitioner notifying them of the Professional Review Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within 30 calendar days of receipt of a Practitioner's request for credentialing or a Practitioner's completed uniform credentialing form, whichever is earlier. This will allow for time to obtain the credentialing form in electronic format, request and obtain third party verification, and make and notify the Practitioner of the decision. The 30-day period will not commence until the applicant provides all requested information or documentation. Copies of the letters are filed in the Practitioner's credentials files.

Recredentialing

Molina recredentials every Practitioner at least every 36 months.

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in Section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, or has a contractual relationship with an entity convicted of a crime specified in Section 1128.

Pursuant to Section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions and Exclusions

Molina monitors the following agencies for Practitioner sanctions and exclusions between recredentialing cycles for all Practitioner types and takes appropriate action against Practitioners when instances of poor quality are identified. If a Molina Practitioner is found to be sanctioned or excluded, the Practitioner's contract will be immediately terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **The OIG High-Risk list –** Monitor for individuals or facilities who refused to enter a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- **State Medicaid Exclusions** – Monitor for state Medicaid exclusions through each State's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Monitor for Medicare exclusions through the CMS MED online application site.
- **Medicare Preclusion List –** Monitor for individuals and entities reported on the Medicare Preclusion List.
- **National Practitioner Database (NPDB)** – Molina enrolls all credentialed Practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Practitioners sanctioned by SAM.

Molina also monitors the following for all Practitioner types between the recredentialing cycles.

- Member Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

Provider Appeal Rights

In cases where the Professional Review Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to laws or regulations.

12. DELEGATION

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

1. Utilization Management
2. Credentialing and Recredentialing
3. Claims
4. Complex Case Management/Care Coordination
5. CMS Preclusion List Monitoring
6. Other clinical and administrative functions

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and reviewed by Molina Delegation Oversight staff for compliance with performance expectations within the timeline indicated by Molina.

Corrective Action Plans and Revocation of Delegated Activities

If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that is the best course of action.

Providers with questions related to delegated functions should contact their Molina Provider Network Manager.

13. COMPLIANCE

Fraud, Waste, and Abuse

Introduction

Molina is dedicated to the detection, prevention, investigation and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan, which addresses how Molina will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste and abuse prevention, detection, and correction along with the education of appropriate employees, vendors, Providers, and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports compliance in its efforts to prevent, detect and correct fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Molina's Mission

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Molina strives to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care costs and promote quality health care.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or,
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The Act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements,

falsifying records, double billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act

The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation or fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims.
- How Providers will detect and prevent fraud, waste, and abuse.
- Employee protection rights as whistleblowers.
- Administrative remedies for false claims and statements.

These provisions encourage employees (current or former) and others to report instances of fraud, waste, or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against due to their role in disclosing or reporting false claims are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority.
- Two (2) times the amount of back pay plus interest.
- Compensation for special damages incurred by the employee because of the employer's inappropriate actions.

Affected entities who fail to comply with the Law will be at risk of forfeiting all payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the law. Health care entities (e.g., providers, facilities, delegates and/or vendors) to which Molina has paid $5 million or more in Medicaid funds during the previous federal fiscal year (October 1-September 30) will be required to submit a signed "Attestation of Compliance with the Deficit Reduction Act of 2005, Section 6032" to Molina.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-kickback Statute (AKS) is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (e.g., drugs, supplies or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks – those who offer or pay

remuneration – as well as the recipients of kickbacks – those who solicit or receive remuneration.
Molina conducts all business in compliance with federal and state AKS statutes and regulations and federal and state marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.
AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by federal and state health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, and contracts not at fair market value, etc. Examples of prohibited AKS actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.
Under Molina's policies, Providers may not offer, solicit an offer, provide or receive items of value intended to induce referrals of federal health care program business. Providers must not directly or indirectly make or offer items of value to any third party for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing Guidelines and Requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both state and federal.
Under Molina's policies, marketing means any communication to a beneficiary who is not enrolled with Molina which can reasonably be interpreted as intended to influence the beneficiary to enroll with Molina's Medicaid, Marketplace, or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another health plan's products.
Restricted marketing activities vary from state to state but generally relate to the types and forms of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach and other types of communications.

Stark Statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the Physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. "Designated health services" are identified in the Physician Self-Referral Law (42 U.S.C. § 1395nn).

Sarbanes-Oxley Act of 2002

The Sarbanes-Oxley Act requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR § 455.2)

Waste means health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, underuse and ineffective use. Inefficiency waste includes redundancy, delays and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent; however, the outcome of poor or inefficient billing methods (e.g., coding) causes unnecessary costs to the Medicaid program.

Abuse means Provider practices that are inconsistent with sound fiscal, business or medical practices, and results in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the state and federal health care programs. (42 CFR § 455.2)

Examples of Fraud, Waste, and Abuse by a Provider

The types of questionable Provider schemes investigated by Molina include, but are not limited to the following:

- A Provider knowingly and willfully refers a Member to health care facilities in which or with which the Provider has a financial relationship (Stark Law).
- Altering claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Molina Member for covered services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing services to Members that are not medically necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of medical necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina Member ID card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.

- Knowingly and willfully solicit or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident-to-billing guidelines in order to receive or maximize reimbursement.
- Overutilization.
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are medically necessary.
- Up-coding, which is when a Provider does not bill the correct code for the service rendered and instead uses a code for a like service that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste and Abuse by a Member

The types of questionable Member schemes investigated by Molina include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud state and federal health care programs.
- Doctor shopping, which occurs when a member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from, and the Member sells the medication to someone else.

Review of Provider Claims and Claim System

Molina Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive, or wasteful billing practices, the billing practice is documented and reported to the Compliance Department.

The claim payment system utilizes system edits and flags to validate those elements of claims are billed in accordance with standardized billing practices, ensure that claims are processed accurately and ensure that payments reflect the service performed as authorized.

Molina performs auditing to ensure the accuracy of data input into the claims system. The claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment of Fraud, Waste and Abuse Detection Activities

Through the implementation of claim edits, Molina's claim payment system is designed to audit claims concurrently, to detect and prevent paying inappropriate claims.

Molina has a pre-payment claim auditing process that identifies frequent correct coding billing errors ensuring that claims are coded appropriately according to state and federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid guidelines, Federal CMS guidelines, American Medical Association (AMA) and published specialty-specific coding rules. Code edit rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD), and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Molina may, at the request of a state program or at its own discretion, subject a Provider to prepayment reviews whereupon the Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the claim will be denied until the Provider can provide sufficient accurate support.

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement with Molina, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement with Molina or at law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement with Molina, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement with Molina, the terms that are expressed here, its rights under law and equity, or some combination thereof.

The Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement with Molina, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where the Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, medical charts, patient charts, billing records, and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, the Provider agrees to repay funds or Molina may seek recoupment.

If a Molina auditor is denied access to the Provider's records, all of the claims for which the Provider received payment from Molina are immediately due and owing. If the Provider fails to provide all requested documentation for any claim, the entire amount of the paid claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to the Provider. The Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which the Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to charge-back.

The Provider acknowledges that HIPAA specifically permits a covered entity, such as the Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 164.501). The Provider further acknowledges that in order to receive payment from Molina, the Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of the Provider under HIPAA and other applicable privacy laws.

Claim Auditing

Molina shall use established industry claim adjudication and/or clinical practices, state and federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding and payment.
The Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of claims and payments by providing access at reasonable times to requested claim information, , the Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. Failure to do so in a timely manner may result in an audit failure and/or denial resulting in an overpayment.
In reviewing medical records for a procedure, Molina reserves the right and where unprohibited by regulation, to select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of claims that Molina paid in error. The estimated proportion, or error rate, may be extrapolated across all claims to determine the amount of overpayment.
Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor-assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's SIU suspects that there is fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Provider Education

When Molina identifies, through an audit or other means, a situation with a Provider (e.g., coding, billing) that is either inappropriate or deficient, Molina may determine that a Provider education visit is appropriate.

Molina will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a corrective action plan (CAP) to Molina addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste, and Abuse

Suspected cases of fraud, waste, or abuse, must be reported to Molina by contacting the Molina AlertLine. The Molina AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. The Molina AlertLine telephone and web-based reporting is available 24 hours a day, 7 days a week, 365 days a year. When a report is made, callers can choose to remain confidential or anonymous. When calling the Molina AlertLine, a trained professional at NAVEX Global will note the caller's concerns and provide them with the Molina Compliance department for follow-up. When electing to use the web-based reporting process, a series of questions will be asked concluding with the submission of the report. Reports to the Molina AlertLine can be made from anywhere within the United States with telephone or internet access.

The Molina AlertLine can be reached at (866) 606-3889 or you may use the service's website to make a report at any time at MolinaHealthcare.alertline.com.

Fraud, waste or abuse cases may also be reported to Molina's Compliance department anonymously without fear of retaliation.
Molina Healthcare of New Mexico, Inc.
Attn: Compliance
P.O. Box 3887
Albuquerque, NM 87190

The following information must be included when reporting:

- Nature of grievance.
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Molina Member ID number, and any other identifying information.

Suspected fraud and abuse may also be reported directly to the State at:

Medical Assistance Division
Quality Assurance Bureau
PO Box 2348
Santa Fe, NM 87504-2348
NMMedicaidFraud@state.nm.us

Local in Santa Fe: (505) 827-3100
Toll-Free: (888) 997-2583

New Mexico Health Care Authority
Office of Inspector General
Local in Albuquerque: (505) 827-8141
Toll-Free: (800) 338-4082
HSDOIGFraud@state.nm.us
Medicaid Fraud Control
Unit 111 Lomas NW, Suite 300
Albuquerque, NM 87102
Local in Albuquerque: (505) 222-9000
Toll-Free: (800) 678-1508

HIPAA Requirements and Information

Molina's Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Molina takes very seriously. Molina is committed to complying with all Federal and State laws regarding the privacy and security of Members' protected health information (PHI).

Provider Responsibilities

Molina expects that its contracted Providers will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

Telehealth/telemedicine Providers: telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law, including:

- 42 C.F.R. Part 2 regulations
- Health Information Technology for Economic and Clinical Health Act, (HITECH Act)

Applicable Laws

Providers must understand all state and federal health care privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead, there is a patchwork of laws that Providers must comply with. In general, most health care Providers are subject to various laws and regulations pertaining to the privacy of health information, including, without limitation, the following:

1. Federal Laws and Regulations

- HIPAA
- The Health Information Technology for Economic and Clinical Health Act (HITECH)
- 42 C.F.R. Part 2
- Medicare and Medicaid laws
- The Affordable Care Act

2. State Medical Privacy Laws and Regulations.

Providers should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Artificial Intelligence

Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to Molina Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician.

Notwithstanding the foregoing, the Provider shall give advance written notice to your Molina Contract Manager (for any AI used by the Provider that may impact the provision of Covered Services to Molina Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by Molina, the Provider further agrees to (i) allow Molina to audit Providers' AI use, as requested by Molina from time to time, and (ii) to cooperate with Molina with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to Molina Members.

If you have additional questions, please contact your Molina Contract Manager.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[26]. Disclosure of

[26]See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.

PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, inpatient review, and retrospective review of "services[27]."
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
    - Quality improvement
    - Disease management
    - Case management and care coordination
    - Training programs
    - Accreditation, licensing, and credentialing

Importantly, this allows Providers to share PHI with Molina for our health care operations activities, such as HEDIS® and quality improvement.

Confidentiality of Substance Use Disorder

Federal confidentiality of substance use disorder patients records regulations apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the federal confidentiality of substance use disorder patients records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

[27]See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. **Notice of privacy practices**
   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.
2. **Requests for restrictions on uses and disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.
3. **Requests for confidential communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests from the patient.
4. **Requests for patient access to PHI**
   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.
5. **Request to amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.
6. **Request accounting of PHI disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity

theft – both financial and medical – is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity– such as health insurance information – without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina.

HIPAA Transactions and Code Sets

Molina strongly supports the use of electronic transactions to streamline health care administrative activities. Molina Providers are encouraged to submit claims and other transactions to Molina using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and Encounters
- Member eligibility status inquiries and responses
- Claim status inquiries and responses
- Authorization requests and responses
- Remittance advices

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

1. Click on the area titled "Health Care Professionals"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

Providers must comply with the NPI rule promulgated under HIPAA. The Provider must obtain an NPI from the NPPES for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters submitted to Molina.

Additional Requirements for Delegated Providers

Providers that are delegated for Claims and utilization management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's privacy and security rules.

Reimbursement for Copies of PHI

Molina does not reimburse Providers for copies of PHI related to our members. These requests may include, although are not limited to, the following purposes:

- Utilization management
- Care coordination and/or complex medical care coordination services
- Claims review
- Resolution of an appeal and/or grievance
- Anti-fraud program review
- Quality of care issues
- Regulatory audits
- Risk adjustment
- Treatment, payment and/or operation purposes
- Collection of HEDIS® medical records

Information Security and Cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by Molina to perform a health plan function(s), and in connection with such delegated functions.

1. Definitions:
   (a) "Molina Information" means any information: (i) provided by Molina to Provider; (ii) accessed by Provider or available to Provider on Molina's Information Systems; or (iii) any information with respect to Molina or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Molina Nonpublic Information.
   (b) "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition, or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized, or unlawful destruction, loss, alteration, use, disclosure of, or access to Molina Information. For clarity, a Breach or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, do not constitute

a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition, or disclosure of Molina Information, or sustained interruption of service obligations to Molina.

(c) "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

(d) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

(e) "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time, and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

i. HIPAA and HITECH
ii. HITRUST Common Security Framework
iii. Center for Internet Security
iv. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1, or as currently revised
v. Federal Information Security Management Act ("FISMA")
vi. ISO/ IEC 27001
vii. Federal Risk and Authorization Management Program ("FedRamp")
viii. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."
ix. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f) "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database, and communications networks (other than the Internet), cloud platforms, architecture interfaces, and firewalls (whether for data, voice, video, or other media access, transmission or reception) and other apparatus used to create, store, transmit, exchange or receive information in any form.

(g) "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

(h) "Nonpublic Information" includes:

i. Molina's proprietary and/or confidential information;
ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal

information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and

iii. Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement, and at all times maintain, appropriate administrative, technical, and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon, and Molina Information that are accessible to, or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical, and physical safeguards pursuant to HIPAA, HITECH, and other applicable U.S. federal, state, and local laws.

(a) Policies, Procedures and Practices. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards, and standards, including as applicable, a written information security program, which Molina shall be permitted to audit via written request, and which shall include at least the following:

i. Access Controls. Access controls, including Multi-Factor Authentication, limit access to the Information Systems and Molina Information accessible to or held by Provider.

ii. Encryption. Use of encryption to protect Molina Information, in transit and at rest, accessible to or held by Provider.

iii. Security. Safeguarding the security of the Information Systems and Molina Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third party vulnerability assessments, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

iv. Software Maintenance. Software maintenance, support, updates, upgrades, third party software components and bug fixes such that the software is, and remains secure from vulnerabilities in accordance with the applicable Industry Standards.

(b) Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:

i. Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

ii. Cloud Services Security: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a service (PaaS), for any services, Provider shall adopt a "zero-trust

architecture" satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii. Data Storage. Provider agrees that any and all Molina Information will be stored, processed, and maintained solely on designated target servers or cloud resources. No Molina Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv. Data Encryption. Provider agrees to store all Molina Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees that any and all Molina Information stored on any portable or laptop computing device or any portable storage medium should likewise be encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v. Data Transmission. Provider agrees that any and all electronic transmission or exchange of system and application data with Molina and/or any other parties expressly designated by Molina shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vi. Data Re-Use. Provider agrees that any and all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Provider. Provider further agrees that no Molina Information or data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Molina.

3. Business Continuity (BC) and Disaster Recovery (DR). Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade, or disrupt Provider's delivery of services to Molina.

(a) Resilience Questionnaire. Provider shall complete a questionnaire provided by Molina to establish Provider's resilience capabilities.

(b) BC/DR Plan.

i. Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format (BC/DR Plans). The BC/DR Plan shall identify the service level agreement(s) established

between Provider and Molina. The BC/DR Plan shall include the following:

a) Notification, escalation, and declaration procedures.
b) Roles, responsibilities and contact lists.
c) All Information Systems that support services are provided to Molina.
d) Detailed recovery procedures in the event of the loss of people, processes, technology and/or third-parties or any combination thereof providing services to Molina.
e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.
f) Detailed list of resources to recover services to Molina including but not limited to applications, systems, vital records, locations, personnel, vendors, and other dependencies.
g) Detailed procedures to restore services from a Cybersecurity Event including ransomware.
h) Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to Molina. Such risk assessment shall evaluate natural, man-made, political, and cybersecurity incidents.

ii. To the extent that Molina Information is held by Provider, Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.

iii. Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

(c) Notification. Provider shall notify Molina's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed 24 hours, of either of the following:

i. Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to Molina or that detrimentally affects Provider's Information Systems or Molina's Information.

ii. Provider's activation of business continuity plans. Provider shall provide Molina with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.

(d) BC and DR Testing. For services provided to Molina, the Provider shall exercise its BC/DR Plan at least once each calendar year. Providers shall exercise their cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider shall provide Molina a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities

performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercise(s).

4. Cybersecurity Events.

(a) Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to, and resolve Cybersecurity Events.

(b) In the event of a Cybersecurity Event that threatens or affects Molina's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or Molina Information accessible to or held by Provider, Provider shall notify Molina's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than 24 hours from Provider's discovery of the Cybersecurity Event.

i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Molina Information, Provider shall notify Molina's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within 24 hours following such payment.

ii. Within 15 days of such a ransom payment that involves or may involve Molina Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment, and evidence of all due diligence and sanction checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

(c) Notification to Molina's Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer
Telephone: (844) 821-1942
Email: CyberIncidentReporting@MolinaHealthcare.com

Molina Chief Information Security Officer
Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

(d) In the event of a Cybersecurity Event, Provider will, at Molina's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by Molina, (ii) fully cooperate with Molina to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers, and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law), and (b) the cost of providing two (2) years of credit monitoring

services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving Molina Information without the prior written consent of Molina.

(e) Following notification of a Cybersecurity Event, Provider must promptly provide Molina any documentation requested by Molina to complete an investigation, or, upon request by Molina, complete an investigation pursuant to the following requirements:
   i. make a determination as to whether a Cybersecurity Event occurred;
   ii. assess the nature and scope of the Cybersecurity Event;
   iii. identify Molina 's Information that may have been involved in the Cybersecurity Event; and
   iv. perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of Molina Information.

(f) Provider must provide Molina with the following required information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina must include at least the following, to the extent known:
   i. the date of the Cybersecurity Event;
   ii. a description of how the information was exposed, lost, stolen, or breached;
   iii. how the Cybersecurity Event was discovered;
   iv. whether any lost, stolen, or breached information has been recovered and if so, how this was done;
   v. the identity of the source of the Cybersecurity Event;
   vi. whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
   vii. a description of the specific types of information accessed or acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer;
   viii. the period during which the Information System was compromised by the Cybersecurity Event;
   ix. the number of total consumers in each State affected by the Cybersecurity Event;
   x. the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
   xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
   xii. a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Molina, the steps

that Provider will take to notify consumers affected by the Cybersecurity Event; and

xiii. the name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

(g) Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon Molina's request.

5. Right to Conduct Assessments; Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If Molina performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider Agreement will be in compliance with generally recognized industry standards and as provided in Provider's response to Molina's due diligence/security risk assessment questionnaire; (ii) agrees to inform Molina promptly of any material variation in operations from what was provided in Provider's response to Molina's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to Molina's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement.
6. Other Provisions. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between Molina and Provider but are not contained in this section.
7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

Member Authorization to Release Protected Health Information English Form: Member Authorization to Release PHI; Spanish Form: Member Authorization to Release PHI.

14. CLAIMS AND COMPENSATION

Payer ID	**09824**
Availity Portal	**Provider.MolinaHealthcare.com**
Clean Claim Timely Filing	**90 calendar days after the discharge for inpatient services or the Date of Service for outpatient services**

Prior to contracting with Molina, Providers must be enrolled with New Mexico Medicaid. All Providers with an NPI that is not associated with an active New Mexico Medicaid Fee-For-Service or Managed Care Provider record (status 60 or 70) in the Omnicaid system and has or will provide health care services are required to enroll with the New Mexico Medical Assistance Division (MAD) Medicaid Program or their claims will be denied.

Barred from Participation

Molina will not make payment to any Practitioner/Provider who has been barred from participation based on existing Medicare, Medicaid, or State Children's Health Insurance Program sanctions, except for Emergency Services.

Reimbursement for Members Who Disenroll While Hospitalized

If a Member is hospitalized at the time of enrollment or disenrollment from an MCO or upon an approved switch to another Turquoise Care MCO, the originating MCO is responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility or a non-psychiatric specialty unit or hospital until the date of discharge. Upon discharge, the Member becomes the financial responsibility of the MCO receiving the capitation payment for that Member.
If a Member is hospitalized and is disenrolled from an MCO due to a loss in Medicaid coverage, the MCO is only financially liable for the inpatient hospitalization and associated professional services until such time that the Member is determined to be ineligible for Medicaid.
If a Member is in a Nursing Facility at the time of disenrollment (not including loss of Medicaid eligibility), Molina may be responsible for the payment of all Covered Services until the date of discharge or the date of disenrollment, whichever occurs first.

Electronic Claim Submission

Molina strongly encourages participating Providers to submit claims electronically, including secondary claims. Electronic claim submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces claim delays since errors can be corrected and resubmitted electronically.
- Eliminates mailing time and claims reach Molina faster.

Molina offers the following electronic Claim submission options:

- Submit claims directly to Molina via the Availity portal.
- Submit claims to Molina via your regular EDI clearinghouse using Payer ID 09824.

Availity Portal

The Availity portal is a no-cost online platform that offers a number of claim processing features:

- Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) claims with attached files.
- Correct/void claims.
- Add attachments to previously submitted claims.
- Check claim status.
- View ERA and EOP.
- Create and manage claim templates.
- Create and submit a claim appeal with attached files.

Clearinghouse

Molina uses the SSI Group, as its gateway clearinghouse. The SSI Group has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit claims to their usual clearinghouse.
If you do not have a clearinghouse, Molina offers additional electronic claim submissions options as shown by logging on to the Availity portal.

Molina accepts EDI transactions through our gateway clearinghouse for claims via the 837P for Professional and 837I for institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 227CA response file with initial status of the claim from your clearinghouse.
- You should refer to the Molina Companion Guide for information on the response format and messages.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

EDI Claim Submission Issues

Providers who are experiencing EDI submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider should contact their Provider Relations Representative for additional support.

Timely Claim Filing

Providers shall promptly submit to Molina claims for covered services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Providers to Molina within 90 days after the discharge for inpatient services or the date of service for outpatient services. If Molina is not the primary payer under the coordination of benefits or third-party liability, Providers must submit claims to Molina within 90 calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any claims that are not submitted to Molina within these timelines below will not be eligible for payment and the Provider hereby waives any right to payment.

Acceptable Proof of Timely Filing - Acceptable proof of timely filing includes, but is not limited to any one item or combination of:

- EOB issued by Molina;
- Provider statements/ledgers indicating the original submission date as well as all follow-up attempts;
- Dated copy of Molina correspondence referencing the Claim (correspondence must be specific to the referenced Claim);
- Other carrier's EOB when Molina is the secondary payer (one [1] year from the date of service);
- Other carrier's EOB when submitted to the wrong carrier (ninety [90] days); and,
- Documentation of inquiries (calls or correspondence) made to Molina for follow-up that can be verified by Molina.

Claims Submission

Participating Providers are required to submit claims to Molina with appropriate documentation and within 90 days from the date of service when Molina is the Member's primary insurance. When Molina is the secondary carrier, the claim must be received within 90 calendar days of the date the other payer paid or denied the claim as reported on the explanation of benefits or remittance advice of the other payer, not to exceed 210 calendar days from the date of service. Participating Providers are required to submit claims to Molina with appropriate documentation. Providers must follow the appropriate state and CMS guidelines. Providers must utilize electronic billing though a clearinghouse or the Availity portal whenever possible and use current HIPAA-compliant American National Standards Institute

(ANSI) X 12N format (e.g., 837I for institutional claims, 837P for professional claims, and 837D for dental claims) and use electronic Payer ID number 09824.
For Members assigned to a delegated medical group/IPA that processes its own claims, please verify the claim submission instructions on the Molina Member ID card.
Providers must bill Molina for services with the most current CMS-approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge.

National Provider Identifier (NPI)

A valid NPI is required on all claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed 30 calendar days from the change. Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Molina may validate the NPI submitted in a claim transaction is a valid NPI and is recognized as part of the NPPES data.

Required Elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state-specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website at MolinaHealthcare.com under EDI>Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan-specific companion guides, which are also available on our website (remember to choose the appropriate state from the drop-down list).

Electronic claim submissions will adhere to specifications for submitting medical claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for Compliance Strategic National Implementation Process (SNIP) levels 1 to 5.

The following information must be included on every claim:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges
- Place and type of service code
- Days or units as applicable (anesthesia claims require minutes)

- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI)
- Rendering Provider information when different than billing
- Billing/Pay-to Provider name and billing address
- Place of service and type for facilities and Outreach/Site Street
- Disclosure of any other health benefit plans
- National Drug Code (NDC), NDC Units, Units of Measure and Days or Units for medical injectables
- E-signature
- Service facility location information
- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of claim submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

Inaccurate, incomplete or untimely submissions and re-submissions may result in denial of the claim.

Claim Submission Forms

Molina requires that all professional claims are submitted on a CMS-1500 Form, and all technical/facility claims are submitted on a CMS-1450 (UB-04) Form with the NPI. For additional information regarding NPI, please refer to the National Provider Identifier (NPI) subsection above.

EDI (Clearinghouse) Submission

Corrected claim information submitted via EDI submission are required to follow electronic claim standardized ASC X12N 837 formats. Electronic claims are validated for compliance with SNIP levels 1 to 5. The 837 claim format allows you to submit changes to claims that were not included in the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called “claim frequency codes.” Using the appropriate code, you can indicate that the claim is an adjustment of a previously submitted finalized claim. Use the below frequency codes for claims that were previously adjudicated.

Claim Frequency Code	Description	Action
7	Use to replace an entire claim.	Molina will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.

8	Use to eliminate a previously submitted claim.	Molina will void the original claim from records based on request.

When submitting claims noted with claim frequency code 7 or 8, the original claim number must be submitted in Loop 2300 REF02 – Payer claim Control Number with qualifier F8 in REF01. The original claim number can be obtained from the 835 ERA. Without the original claim number, adjustment requests will generate a compliance error and the claim will be rejected.

Claim corrections submitted without the appropriate frequency code will be denied as a duplicate and the original claim number will not be adjusted.

Paper Claim Submission

Participating Providers should submit claims electronically. If electronic claim submission is not possible, please submit paper claims to the following address:

Molina Healthcare of New Mexico, Inc.
PO Box 22801
Long Beach, CA 90801

When submitting paper claims:

- Paper claim submissions are not considered to be "accepted" until received at the appropriate claims PO Box; claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper claims are **required** to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) claim forms.
- Paper claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include claims with handwriting.
- Claims must be typed with either 10 or 12 point Times New Roman font, using black ink.
- Link to paper claims submission guidance from CMS: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500.

Corrected Claims

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

Molina strongly encourages participating Providers to submit corrected claims electronically via EDI or the Availity portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper claims).

- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 claim form (paper claims).
- Original claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the National Uniform Claim Committee (NUCC) manual for CMS-1500 claim forms or the Uniform Billing (UB) Editor for CMS-1450 (UB-04) claim forms.

Corrected claims must be submitted within 90 calendar days of the date of service or discharge date.

Corrected Claim submission options:

- Submit corrected claims directly to Molina via the Availity portal.
- Submit corrected claims to Molina via your regular EDI clearinghouse.

Itemized Statements for Claims

Itemized Statements requested by Molina must be attached to the claim and should be attached as a corrected claim in the Availity portal.

Coordination of Benefits (COB) and Third-Party Liability (TPL)

Third-party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the Member.

Medicaid is always the payer of last resort and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina Members. If third-party liability can be established, Providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for secondary claim processing. In the event that coordination of benefits occurs, Providers shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the claim submission. Providers can submit claims with attachments, including EOB and other required documents. Molina will pay claims for prenatal care and preventive pediatric care and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third-party liability, an overpayment notification letter will be sent to the Provider requesting a refund, including third-party policy information required for billing.

Subrogation - Molina retains the right to recover benefits paid for a Member's health care services when a third party is responsible for the Member's injury or illness to the extent permitted under state and federal law and the Member's benefit plan. If third-party liability is suspected or known, please refer pertinent case information to Molina's vendor, Optum, at submitreferrals@optum.com.

Hospital-Acquired Conditions (HAC) and Present on Admission (POA) Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidence-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting."

The following is a list of CMS hospital acquired conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission:

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility
4) Stage III and IV Pressure Ulcers
5) Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries
    e) Burn
    f) Other Injuries
6) Manifestations of Poor Glycemic Control
    a) Diabetic Ketoacidosis
    b) Nonketotic Hyperosmolar Coma
    c) Hypoglycemic Coma
    d) Secondary Diabetes with Ketoacidosis
    e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft – (CABG)
10) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a) Laparoscopic Gastric Bypass
    b) Gastroenterostomy
    c) Laparoscopic Gastric Restrictive Surgery
11) Surgical Site Infection Following Certain Orthopedic Procedures:
    a) Spine
    b) Neck

c) Shoulder
d) Elbow

12) Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
13) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a) Total Knee Replacement
    b) Hip Replacement
14) Iatrogenic Pneumothorax with Venous Catheterization

What this means to Providers

- Acute Inpatient Prospective Payment System (IPPS) hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

For additional information on the Medicare HAC/POA program, including billing requirements, please refer to the CMS website at cms.hhs.gov/HospitalAcqCond/.

Health Care Acquired Conditions (HCAC) and Never Events

Molina has an established and systematic process to identify, investigate and review any Quality of Care, Adverse Event/Never Event, and/or service issues affecting Member care. This process includes researching the issue, resolution of the issue, and tracking facilities and Providers for trend issues. Confirmed Adverse Events/Never Events are reported to Molina's Professional Review Committee for recommendations and/or case closure. If it is determined that a HAC has occurred, payment will be denied. In such instances, please note that the Provider is not allowed to bill the Member.

Molina Coding Policies and Payment Policies

Frequently requested information on Molina's coding policies and payment policies is available on the MolinaHealthcare.com website under the Policies tab. Questions can be directed to your Provider Relations Representative.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate claims. Molina requires coding of both diagnoses and procedures for all claims as follows:

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
- For procedures:
  - Professional and outpatient claims require the Healthcare Common Procedure Coding System, Current Procedural Terminology Level 1 (CPT codes), Level 2 and 3 HCPCS codes.

- Inpatient hospital claims require International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) coding schemes

Furthermore, Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Molina utilizes a claim adjudication system that encompasses edits and audits that follow state and federal requirements, as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by CMS, including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). In the event a state benefit limit is more stringent/restrictive than a federal MUE, Molina will apply the state benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a federal MUE or state benefit limit the professional organization standard may be used.
  - In the absence of state guidance, Medicare National Coverage Determinations (NCD).
  - In the absence of state guidance, Medicare Local Coverage Determinations (LCD).
  - CMS Physician Fee Schedule RVU indicators.
- CPT guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than state and federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

Telehealth Claims and Billing

Providers must follow CMS guidelines as well as state-level requirements.
All telehealth claims for Molina Members must be submitted to Molina with the correct codes for the plan type in accordance with applicable billing guidelines. For guidance, please refer to hsd.state.nm.us/wp-content/uploads/8.310.2-NMAC and hca.nm.gov/wp-content/uploads/BEHAVIORAL-HEALTH-POLICY-AND-BILLING-MANUAL-FINAL-12.23.21.

National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. Molina uses NCCI standard payment methodologies.
NCCI procedure to procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on the NCCI coding manual and CPT guidelines, some services/procedures performed in conjunction with an

evaluation and management (E&M) code will bundle into the procedure when performed by the same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUE) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

Correct coding is required to properly process claims. Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two (2) alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component
- Service or procedure has a technical component
- Service or procedure was performed by more than one (1) physician
- Unilateral procedure was performed
- Bilateral procedure was performed
- Service or procedure was provided more than once
- Only part of a service was performed

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS codes

Molina utilizes ICD-10-CM and ICD-10-PCS billing rules and will deny claims that do not meet Molina's ICD-10 claim submission guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service for which the procedure or service was

rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

POS codes are two (2)-digit codes placed on health care professional claims (CMS-1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS code should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS code for the procedure/service on that line.

Type of Bill

Type of bill is a four (4)-digit alphanumeric code that gives three (3) specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official UB-04 Data Specifications Manual.

Revenue Codes

Revenue codes are four (4)-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official UB-04 Data Specifications Manual.

Diagnosis Related Group (DRG)

Facilities contracted to use DRG payment methodology submit claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate claim payment.
Molina processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Molina-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code (NDC)

The NDC number must be reported on all professional and outpatient claims when submitted on the CMS-1500 Claim form, CMS-1450 (UB-04) or its electronic equivalent.

Providers will need to submit claims with both HCPCS and NDC codes with the exact NDC number that appears on the medication packaging in the 5-4-2 digit format (i.e., xxxxx-xxxx-xx)

as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

Coding Sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three (3) types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a CMS-maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS - International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

Claim Auditing

Molina shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding and payment.
The Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. The Provider shall cooperate with Molina's Special Investigations Unit and audits of claims and payments by providing access at reasonable times to requested claims information, the Provider's charging policies and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.
In reviewing medical records for a procedure, Molina reserves the right, and where unprohibited by regulation, to select a statistically valid random sample, or smaller subset of the statistically valid random sample. This sample gives an estimate of the proportion of claims

Molina paid in error. The estimated proportion, or error rate, may be extrapolated across all claims to determine the amount of overpayment.
Provider audits may be telephonic, an on-site visit, internal claim review, client-directed/regulatory investigation and/or compliance reviews and may be vendor-assisted. Molina asks that you provide us, or our designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.
If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Claim Review

Claim will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, current Uniform Billing (UB) manual and editor, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS), federal, and state billing and payment rules, National Correct Coding Initiative (NCCI) Edits, and Federal Drug Administration (FDA) definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Furthermore, the Provider acknowledges Molina's right to conduct Medical Necessity reviews and apply clinical practices to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or certain items which do not meet certain Medical Necessity criteria.

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider Agreement with Molina. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process 90% of all clean claims within 30 calendar days and 99% of all clean claims within 90 calendar days of receipt of clean claims.
Claims from I/T/Us, Day Activity Providers, Assisted Living Providers, Nursing Facilities, and Home Care Agencies, including Community Benefit Providers, must have 95% of clean claims adjudicated within 15 calendar days from receipt of clean claim, and 99% or more of clean claims should be adjudicated within 30 calendar days of receipt of clean claim.

The receipt date of a claim is the date Molina receives notice of the claim.

Electronic Claim Payment

Participating Providers are required to enroll for EFT and ERA. Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork and provide searchable ERAs. Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and

Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at MolinaHealthcare.com or by contacting the Molina Provider Contact Center.

Overpayments and Incorrect Payments Refund Requests

Molina requires network Providers to report to Molina when they have received an overpayment and to return the overpayment to Molina within 60 calendar days after the date on which the overpayment was identified and notify Molina in writing of the reason for the overpayment.

If, as a result of retroactive review of claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a claim for such Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with state and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment.
2. Submit request to offset future claim payments.
3. Dispute overpayment findings.

A copy of the overpayment request letter and details are available in the Availity Portal. Providers can make an inquiry, contest an overpayment with supporting documentation, resolve an overpayment or check status. This is Molina's preferred method of communication.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Molina standards and may vary depending on applicable state guidelines and contractual terms.

A Provider shall pay a claim for an overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the time frame allowed Molina may offset the Overpayment amount(s) against future payments made to the Provider.

Interest

Molina will pay interest each month on the amount of a clean claim (based upon the current Medicaid fee schedule) and not paid within 30 calendar days of the date of receipt of an electronic claim. Interest will accrue from the 31st calendar day.

Self-Reporting

Practitioner/Provider are required to report identified overpayments within 60 calendar days from the date on which the Practitioner/Provider identifies an overpayment, or the date any corresponding cost report is due, if applicable. A Practitioner/Provider has identified an overpayment if the Practitioner/Provider has actual knowledge of the existence of an overpayment or acts in reckless disregard or with deliberate indifference that an overpayment exists, the Practitioner/Provider must send an "Overpayment Report" to the CONTRACTOR and HCA, which must include:

- Provider's name.
- Provider's tax identification number and National Provider Number.
- How overpayment was discovered.
- The reason for the overpayment.
- The health insurance claim number, as appropriate.
- Date(s) of service.
- Medicaid claim control number, as appropriate.
- Description of a corrective action plan to ensure the Overpayment does not occur again.
- Whether the Provider has a corporate integrity agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under the OIG Self-Disclosure Protocol.
- The specific dates (or timespan) within which the problem existed that cause the overpayments.
- If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- The refund amount.

Refunds

All self-reported refunds for overpayments must be made by the Provider to Molina as an intermediary and are the property of Molina unless HCA, the Recovery Audit Contractor or Medical Fraud and Elder Abuse Division of the New Mexico Attorney General's Office independently notified the Provider that an overpayment existed or Molina fails to initiate recovery within 12 months from the date the CONTRACTOR first paid the claim; or fails to complete the recovery within 15 months from the date it first paid the claim. In cases where HCA, the RAC or MFEAD identifies the overpayment, HCA will seek recovery of the Overpayment in accordance with NMAC § 8.351.2.13.

The Provider may:

- Request that Molina permit installment payments of the Refund, such request be agreed to by Molina and the Provider; or,
- In cases where HCA, the RAC or MFEAD identify the Overpayment, HCA will seek recovery of the Overpayment in accordance with NMAC § 8.351.2.13.

Failure to Self-Report and/or Refund Overpayments

Overpayments that have been identified by the Provider and not self-reported within the 60 day timeframe are presumed to be false claims and are subject to referrals as Credible Allegations of Fraud.

Claim Disputes/Reconsiderations/Appeals

Providers disputing a claim previously adjudicated must request such action within 90 calendar days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.) all claim disputes must be submitted on the Molina Provider Reconsideration Review Request Form (PRR) found on Molina's website at MolinaHealthcare.com and the Availity portal. The form must be filled out completely in order to be processed.

Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following documentation:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.
- The Claim number is clearly marked on all supporting documents.

Forms may be submitted via fax, secure email, or mail. Claims Disputes/Reconsideration requested via the PRR may be sent to the following address:

Molina Healthcare of New Mexico, Inc.
Attention: Claims Disputes/Adjustments
PO Box 182273
Chattanooga, TN 37422
Submitted via fax: (855) 378-3642

Please Note: Requests for adjustments of Claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original Claim.

The Provider will be notified of Molina's decision in writing within 30 days of receipt of the Claims Dispute/Adjustment request.

Claim Resubmission/Adjustments

All requests must include sufficient documentation to support the request. The Molina Provider Reconsideration Request (PRR) can be accessed on Molina's website at MolinaHealthcare.com.

All claim adjustment requests must be submitted and received by Molina within:

- 90 days of dated correspondence from Molina referencing the claim (correspondence must be specific to the referenced claim);

- One (1) year from the date of service when Molina is the secondary payer when the primary carrier's filing limit is one (1) year, and 90days of the other carrier's EOB; and,
- 90 days of the other carrier's EOB when submitted to the wrong payer.

Claim Editing Process

Molina has a claims pre-payment auditing process that identifies frequent billing errors such as:

- Bundling and unbundling coding errors
- Duplicate claims
- Services included in global care
- Incorrect coding of services rendered

Coding edits are generally based on state fee-for-service Medicaid edits, AMA, CPT, HRSA and NCCI guidelines. If you disagree with an edit, please refer to the Claim Resubmission/Adjustments subsection above.

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

Members Held Financially Harmless

- Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
- Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider.
- The Provider agrees to accept payment from Molina as payment in full or bill the appropriate responsible party.

The Practitioner/Provider will not seek to collect, accept payment from, or bill Molina Members any amounts except applicable co-payments or coinsurance for the provision of covered services over and above those paid for by Molina.

Practitioners/Providers who participate in Medicaid agree to accept the amount paid as payment in full (see 42 C RF 447.15) with the exception of copayment amounts required in certain Medicaid categories (Native Americans are exempt from co-payment requirements).

Aside from copayments, a Provider may not bill a Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:

- The Member has been advised by the Provider that the service is not a covered benefit;
- The Member has been advised by the Provider that they are not contracted with Molina; and/or
- The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

Fraud, Waste, and Abuse

Failure to report instances of suspected fraud, waste and abuse is a violation of the law and subject to the penalties provided by law. For additional information, please refer to the **Compliance** section of this Provider Manual.

Encounter Data

Each Provider, capitated Provider or organization delegated for claims processing is required to submit Encounter data to Molina for all adjudicated claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement (QI) program and HEDIS® reporting.
Encounter data must be submitted within 30 to 60 days from claim adjudication to meet state and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA-compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D – Dental. Data must be submitted with claims level detail for all non-institutional services provided.
Molina has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and proprietary formats if needed.
Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within 15 days from the rejection/denial.
Molina has created 837P, 837I and 837D Companion Guides with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two (2) types of responses:

- First, Molina will provide a 999 acknowledgement of the transmission.
- Second, Molina will provide a 277CA response file for each transaction.

Molina is required by the New Mexico Health Care Authority to report all services rendered to Molina Members. The reporting of these services, also known as encounter data reporting, is a critical contractual requirement. Molina works closely with its Providers and subcontractors to ensure they comply with Encounter Data submission requirements. This includes training, technical assistance and other activities to support Providers and subcontractors to ensure compliance with the HIPAA 837 format. Molina also partners with SSI to identify opportunities

to assist Practitioners/Providers to use electronic claims submission and improve the quality of claims and encounter data submitted.

15. MEMBER ADVOCACY - GRIEVANCE, APPEAL AND FAIR HEARING PROCESS

This section describes the process to be used by Practitioners/Providers assisting Members with grievances and appeals, and for Providers filing a grievance or appeal on their own behalf. The processes for Members will be discussed first.

- A **grievance** is any dissatisfaction voiced by any Member on any aspect of their health care or health benefits plan *other* than a request for services.
- An **appeal** is a request for review of a denied specific health care service or non-payment for a health care service.
- Grievances and appeals are reviewed and resolved to promote Member satisfaction and in compliance with applicable state and federal law, regulations, and guidelines. Grievances are processed confidentially. Molina employees are required to sign a confidentiality statement at the time of hire.
- No person will be subject to retaliatory action by Molina for any reason related to grievances or appeals.

Assisting Molina Members When They Have a Grievance or Appeal

When Practitioners/Providers are trying to help a patient get a service covered, or have a grievance or appeal addressed, Molina Member grievance or appeal processes apply. The Member may select someone of their choosing, including an attorney (at the Member's expense) to represent their grievance or appeal. If someone other than the Member files a grievance on the Member's behalf, an authorization to represent the Member must be submitted to Molina. ***If you are filing a grievance or appeal on behalf of a Member, you must submit a signed authorization form from the Member before Molina can accept the grievance or appeal request. This authorization form can be found by following this link: Provider Forms***
If you receive a grievance or an issue from a Molina Member, please ask the Member to contact the Molina Member Services department. If a Member is unable to call Molina for any reason, we ask that you take the basic information about the grievance or appeal from the Member. The information to file a written grievance or appeal on the Member's behalf may be sent via mail or fax to the attention of the Appeals department at the address or fax number listed in this section.
The Member, the authorized representative of the Member, in the case of minors or incapacitated adults, the Member's Provider, or the representative of the Member with the Member's written consent, has the right to file a written or oral grievance or appeal to Molina or to the State of NM Health Care Authority (HCA) Hearings Bureau on behalf of the Member. This information is also provided to Members in the Member Handbook. As previously discussed, if you are filing a grievance or appeal on behalf of the Member, you must submit a signed authorization form from the Member before Molina can accept the grievance or appeal request.

Filing a Formal Verbal or Written Grievance or Appeal for Members

Molina's Appeals department for Members is also known internally as the Member Advocacy department. The Member or representative of the Member (with the Member's written consent) has the right to file a formal verbal or written grievance or appeal if they are dissatisfied with some aspect of Molina (i.e., Provider or health care received or requested and not received).
A Member or their representative may file an appeal for a Molina Adverse Benefit Determination within 60 calendar days of receiving Molina's notice of Adverse Benefit Determination, i.e., denial. Oral inquiries from Members seeking to appeal an Adverse Benefit Determination are treated as appeals in order to establish the earliest filing date for the Appeal. Molina accepts, investigates, and provides a written resolution to all oral appeal requests. An oral appeal must be followed by a written appeal that is signed by the Member within 13 calendar days. Failure to file the written appeal within 13 calendar days will constitute withdrawal of the appeal. Molina will make its best efforts to assist the Member as needed with the written appeal.
A network Provider also has the right to file a formal verbal or written appeal with Molina, on the Member's behalf with the Member's written consent, if the Member is dissatisfied with Molina's decision to terminate, suspend, reduce or not provide services to a Member.

To submit a formal verbal or written grievance or appeal on behalf of a Molina Member, call or write to:

Molina Healthcare of New Mexico, Inc.
Attention: Appeals Department
PO Box 182273
Chattanooga, TN 37422
Phone: Albuquerque (505) 342-4681 or Toll-Free (800) 580-2811 Fax: (505) 342-0583.
Email: MNM.Medicaid.MemberAppealsandGrievances@molinahealthcare.com

Basic information needed when initiating a formal verbal or written grievance or appeal on behalf of a Member are:

- Member name
- The Molina Member ID number
- Telephone number (where Member can be reached during the day)
- A brief description of the issue(s)

All formal verbal or written grievances and appeals are to be reported to Molina, which relies on Providers' assistance in facilitating the notification process and helping resolve the Member's issues as quickly as possible. If a Provider or someone other than the Member files a formal verbal or written grievance or appeal on any Member's behalf, an authorization to represent that Member must be submitted to Molina.
When Practitioners/Providers assist a Molina Member in trying to get a service covered, or a formal verbal or written grievance or appeal addressed, Molina Member grievance and appeal

processes apply. At any level of the formal verbal or written grievance and appeal process, the Member can select someone of their own choosing to represent them. This includes the authorized representative of the Member in the case of a minor or incapacitated adult, Providers working on behalf of the Member with the Member's written permission, and/or an attorney (at the Member's expense) to represent them.
Please contact Molina if any Member needs the grievance and appeal information in a language other than English. Translation Services and Teletype/Telecommunication Device for the Deaf (TTY/TDD) services for the hearing impaired are also available.

Accessing TTY/TDD Services

Our Grievance and Appeal Line is accessible to all Members. Members who are deaf, hard of hearing, or have a speech impairment can communicate with Molina through the Relay New Mexico (Relay NM) Network. This service is available 24 hours a day, 7 days a week. Members may access Relay NM by following these directions:

- Using your TTY text telephone, call the Relay NM operator **toll-free at (800) 659-8331**.
- Type your message to the Relay NM operator, informing them that they would like to contact the Molina Member Services department in **Albuquerque at (505) 341- 7493 or toll-free at (855) 322-4078.**
- The Relay NM operator voices the typed conversation to the Molina Member Service Representative answering the call.
- The Member Service Representative can converse with the Member through the Relay NM operator, who then types the verbal communication to the Member.
- Molina Appeals staff can also contact Members using the TTY text telephone by calling Relay NM **toll-free at (800) 659-1779** and asking the Relay NM Operator to call the Member and type the conversation to the Member.

Conversations are kept confidential by Molina and Relay NM. Relay NM does not maintain records of actual conversations.

Expedited Review Processes

Internal/external expedited reviews on pre-service denials will be completed for all Members in accordance with the medical urgency of the case and will not exceed 72 hours whenever:

- The life or health of a covered person may be jeopardized.
- The covered person's ability to attain, maintain or regain maximum function may be jeopardized.

Such determination is based on:

- A request from the Member.
- A Practitioner/Provider's support of the Member's request.
- A Practitioner/Provider's request on behalf of the Member.
- Molina's independent determination.

If the expedited review request is denied, the Member and the Practitioner/Provider are notified, and the review is placed in the standard review time frame 30 calendar days to resolve.

Processing Member Formal Grievance and Appeals

Molina provides to the Member and/or their representative, the opportunity before and during the appeal process, to examine the case file, including medical records and other documents and records considered during the appeal process that are not considered as confidential or privileged information. Molina will include as parties to the grievance or appeal, the Member and their representative, or the legal representative of a deceased Member's estate.

- The grievance or appeal will be reviewed by a committee of one or more Molina employees, who did not participate in any previous level of review or decision-making, including staff with expertise in the issue(s) under review.
- When resolved, the Appeals Staff will inform the Member of the outcome of the review by letter. If the Member is dissatisfied with the resolution, the Member may appeal the decision with Molina. If dissatisfied with an appeal outcome, the Member may also appeal to HCA and request a Fair Hearing.

The written decision will include the following:

- The results of the grievance or appeal review.
- The date the review of the grievance or appeal was completed.
- All information considered in investigating the grievance or appeal.
- Findings and conclusions reached based on the investigation results.
- Disposition of the grievance or appeal.

If a denial has been upheld in whole or in part, the following information will also be provided:

- Information regarding the fact that the Member may, with a written request, receive reasonable access to and copies of all documents relevant to the appeal as allowed by law.
- Information on the Member's right to request a Fair Hearing to appeal the decision to the HCA Hearings Bureau within 90 calendar days of the decision.
- The right to request the continuation of benefits while the hearing is pending, and how to make this request.
- A statement that the Member may be held liable for the cost of those appealed benefits if the hearing decision upholds Molina's original decision/Adverse Benefit Action.

Requesting a Fair Hearing for Members

Members may request a Fair Hearing with HCA **after the appeals process has been exhausted with Molina:**

Hearings Bureau
PO Box 2348

Santa Fe, NM 87504-2348
Santa Fe (505) 476-6213 or Toll-Free (800) 432-6217, option #6; Fax: (505) 476-6215

When the HCA receives a request for a Fair Hearing to appeal Molina's final decision, an official record of the appeal and copy of Molina's final decision will be submitted to the HCA Hearings Bureau.

Continuation of Benefits While Awaiting the HCA Fair Hearing

Molina will continue the Member's benefits while the appeal and/or HCA Fair Hearing process is pending at the Member's request for continuation.

The Member will be responsible for repayment of services provided to the Member if the Fair Hearing decision is not in the Member's favor.

Molina will provide benefits until one of the following occurs:

- The Member withdraws the appeal.
- An HCA administrative law judge issues a hearing decision adverse to the Member.
- The time period of service limits of a previously authorized service has expired.

If the final resolution of the appeal is adverse to the Member, Molina may recover the cost of the services furnished to the Member while the appeal was pending to the extent that services were furnished solely because of the benefit continuation requirement.

If Molina or an HCA administrative law judge reverses a decision to deny, limit or delay services, and:

- If the Member did not receive the disputed services while the appeal was pending, Molina will authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires; and/or,
- If the Member received the disputed services while the appeal was pending, Molina will pay for these services.

Time Limitations

Processing of grievance and appeals for Members must be completed within 30 calendar days from the date a written or verbal grievance or appeal request is received. If a delay is incurred, the Member will be notified before the 30th day. Molina may extend the 30-day timeframe by 14 calendar days if the Member requests the extension, or it is demonstrated to HCA that there is need for additional information, and the extension is in the Member's best interest.

A formal Member appeal request must be filed within 60 calendar days of the date of Molina's notice of action.

Timelines for Member Appeals

Grievance or Appeal Type	When Applied	Timelines
Expedited Resolution of Appeal Request	When taking the time for a standard resolution could seriously jeopardize the Member's life or s health.	• 72 hours - Oral decision notice • 2 calendar days from the date of the oral decision notice - Written decision notice
Denial for an expedited resolution request	When the request for an expedited resolution does not meet expedited review guidelines.	• 2 calendar days - Written confirmation and a reasonable effort to provide verbal notice • 30 calendar days - To resolve the issue
Automatic Appeal	When an expedited service authorization rendered by Molina denies or authorizes a service in an amount, duration, or scope less than was requested by the Provider.	• 72 hours - Written decision notice and best effort to provide oral decision notice.
Oral or written pre- or post- service Appeal	When a Member makes an oral or written inquiry seeking to Appeal an action, the inquiry is treated as an Appeal, pre- or post-service.	• 5 business days - Acknowledgement is sent to the Member after receipt of the request • 30 calendar days - To resolve the issue.
Review Extension	When the Member requests the extension or Molina can demonstrate the need for additional information.	• 14 calendar days - To resolve. • 2 business days - Written confirmation of reason for extension when Molina requests the extension.
Filing limit	Applies to timeframe that an Appeal is considered.	• 60 calendar days - From date of occurrence or notice of action.
Appeal Files	Applies to timeframe that Appeal files are retained.	• 10 years - From final decision date.

16. PROVIDER GRIEVANCE, RECONSIDERATION AND APPEAL PROCESSES

Molina ensures that Providers may bring to its attention their concerns regarding the operation of the plan, reimbursement disputes, claims denials due to lack of prior authorization, timeliness issues, concerns regarding quality of and access to health care services, the choice of health care Providers and the adequacy of the contracted network.

Provider concerns addressed here are specific to Provider interests (as opposed to individual Member interests or Provider issues initiated on behalf of a member). Provider grievances and appeals are evaluated in a consistent, impartial and timely manner to ensure compliance with state and federal laws, regulations and standards.

Provider Grievances may be submitted by telephone, by fax, via email or in writing. Providers may generate a grievance by calling the Molina Provider Contact Center during regular business hours at (855) 322-4078.

Written Provider Appeals must be submitted via the Availity portal or faxed toll-free to (855) 378-3643.

Grievances may be submitted for such things as a dissatisfaction about a Molina Member or employee or about the health plan. Issues that are not related to a Molina action are not eligible for appeal. Every effort will be made to resolve grievances at an informal level to the Provider's satisfaction whenever possible.

Initial disputes/disagreements with claim payments/denials are handled as a Provider Reconsideration Review Request (PRR) and not considered formal appeals.

Examples of PRRs include:

- Disagreement with payment amount or denial of a claim; and/or;
- Claim edit disputes.

Formal Appeals include:

- Denial of a claim due to a Utilization Management decision (denial of prior authorization); and/or;
- Disagreement with a PRR decision.

Appeals must be submitted in writing to Molina for Utilization Management issues (e.g., denials resulting from not obtaining prior authorization for some or all types of services and/or for all dates of service), and for PRR denials.

Registering and responding to Provider grievances and appeals is performed by a member of the Appeals department. The activities involved in registering and responding to Provider grievances or appeals include the following:

- Notification of the review results in writing within 30 calendar days;
- Documenting the substance of the grievance or appeal and the actions taken;
- Coordinating appeal reviews with the applicable department representative(s) responsible for the particular service(s) that are the subject of the grievance or appeal; and,
- Notification to the Provider of the appeal disposition.

The Appeals department coordinates relaying Provider grievance and appeal information to internal quality improvement committees.

Written notifications to the Provider of appeal review determination decisions will include the following elements:

- The names and titles of the reviewers;
- A statement of the reviewer's understanding of the nature of the appeal and all pertinent facts;
- Reference to the evidence or documentation considered by the reviewer(s) in making the decision as applicable; and,
- An explanation of the rationale for the reviewer's decision.

Timeline Grid

Type	Timeline
Grievances	• Filing Limit: 90 calendar days from the date of dissatisfaction. • Resolution: No more than 30 calendar days from receipt.
Appeals	• Filing Limit: 90 calendar days from the date of notice action. • Resolution: 30 calendar days from receipt.

Appeal Process

When a Provider appeal is submitted in writing to Molina, the resolution of the appeal will include the following:

- The Appeals department staff member assigned to the appeal will coordinate and document the investigation of the substance of the appeal;
- Molina will appoint one or more persons responsible for the substantive area addressed by the concern to review the appeal and will grant the reviewers the authorization to take appropriate corrective action on the issue;
- The Provider is encouraged to present additional data pertinent to the appeal, including but not limited to, written materials, medical records, and medical literature; and,
- The Appeals department will mail a written decision from the internal review to the Provider within 30 calendar days from the date the appeal is received.

Confidential Information

- When reviewing grievances and appeals, Molina will treat all identifying information of Members in accordance with the rules and regulations of HIPAA, except as otherwise provided by state law and internal policy and procedure;
- To ensure confidentiality, information needed for a grievance or appeal review is available to Molina staff member(s) who have a business need for the information, as required by HIPAA Minimum Necessary Rule guidance. In most cases, access is limited only to those staff Members who are conducting the review.

The Provider will not be subject to retaliation for filing a grievance or appeal.

Upon receipt, the issue is reviewed by the Appeals staff and the grievance or appeal is processed accordingly.

Molina will maintain confidential **locked files** located in the Appeals department, or secure electronic files, for all issues received.

Each file will identify and/or contain:

- Date the grievance or appeal was received;
- The name and address of the Provider;
- The name of the person requesting the grievance or appeal or the name of the person on whose behalf the issue is being opened;
- The line of business under which the Provider is contracted;
- Name of the staff member assigned to the issue;
- A description of the issue;
- Grievance or appeal type/level;
- Name of reviewer(s) and the final outcome;
- The date the issue was resolved and the date the Provider was notified of the outcome; and,
- Grievance and appeal files will be maintained for a period of no less than 10 years.

Reporting of Provider Grievances and Appeals

Provider grievances and appeals are reported to Molina's governing body, the Board of Directors, through the Member and Provider Satisfaction Committee (MPSC) semi-annual. Grievances and appeal data are reported to HCA/MAD.

Provider Reconsideration Review Request (PRR) Form

Please use the Molina PRR Form when submitting a claim adjustment request. This form can be accessed via the Availity portal or on the Molina website at MolinaHealthcare.com.

- A PRR Form is required for each claim;

- This form must be completely filled out, or it will be returned;
- Attach a legible copy of the claim and remittance advice;
- Upon receipt of this form and additional necessary information, the request will be reviewed and sent for processing if appropriate;
- If the request is declined, a letter will be sent with the denial reason;
- If you disagree with the PRR denial, you will have 90 days from the date of the denial letter to appeal; and.
- Submit the PRR Form and the necessary attachments to: Toll-Free fax (855) 378-3642

If you have any questions or need additional copies of the PRR Form, please contact Provider Contact Center toll-free at (855) 322-4078 and a representative will be glad to assist you.

17. QUALITY

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement (QI) program. You can contact the Molina Quality department at (855) 322-4078.

The address for mail requests is:

Molina Healthcare of New Mexico, Inc.
Attn: Quality Department
P.O. Box 3887
Albuquerque, NM 87190

This Provider Manual contains excerpts from the Molina QI program. For a complete copy of Molina's QI program, you can contact your Provider Relations representative or call the telephone number above to receive a written copy.

Molina's QIP complies with regulatory and accreditation guidelines. The QIP provides structure and outlines specific activities designed to improve the care, service and health of our Members.

Molina has established a QI program that complies with regulatory requirements and accreditation standards. The QI program provides structure and outlines specific activities designed to improve the care, service and health of Molina Members. Molina's QI program description describes the program governance, scope, goals, measurable objectives, structure and responsibilities.

Molina does not delegate quality improvement activities to medical groups/IPAs. However, Molina requires contracted medical groups/IPAs to comply with the following core elements and standards of care. Molina medical groups/IPAs must:

- Have a quality improvement program in place
- Comply with and participate in Molina's QI program, including reporting of access and availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential quality of care and/or critical incident investigations
- Cooperate with Molina's quality improvement activities that are designed to improve quality of care and services and Member experience.
- Allow Molina to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service and access and availability
- Allow access to Molina Quality personnel for site and medical record review processes.

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe health practices for our Members through our safety program, pharmaceutical management and care coordination/health management programs and education. Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital-acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), and the Department of Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

Molina has an established and systematic process to identify, investigate, review and report any quality of care, adverse event/never event, critical incident (as applicable), and/or service issues affecting Member care. Molina will research, resolve, track and trend issues. Confirmed adverse events/never events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgery on a patient

Molina is not required to pay for inpatient care related to "never events."

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's medical record. PCPs should maintain the following components:

- Medical record confidentiality and release of medical records are maintained including behavioral health care records;
- Medical record content and documentation standards are followed, including preventive health care;
- Storage maintenance and disposal processes are maintained; and,
- The process for archiving medical records and implementing improvement activities is outlined.

Medical Record Keeping Practices

Below is a list of the minimum items that are necessary in the maintenance of the Member's medical records:

- Each patient has a separate medical record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available during each visit and archived records are available within 24 hours.
- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when the thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for quality and HIPAA compliance, including privacy of confidential information, such as race, ethnicity, language, and sexual orientation and gender identity.
- Storage maintenance for the determined timeline and disposal are managed per record management processes.
- The process is in place for archiving medical records and implementing improvement activities.
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records.

Content

Providers must remain consistent in their practices with Molina's medical record documentation guidelines. Medical records are maintained and should include, but not limited to, the following information. All medical records should contain:

- The patient's name or ID number on each page in the record contains the patient's name or ID number.
- The patient's name, date of birth, sex, marital status, address, employer, home and work telephone numbers and emergency contact.
- Legible signatures and credentials of the Provider and other staff Members within a paper chart.
- A list of all Providers who participate in the member's care.
- Information about services that are delivered by these Providers.
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting grievances, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within 30 days of an inpatient discharge with evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions or notation that none are known.

- Documentation that shows advanced directives, power of attorney and living will have been discussed with the Member, and a copy of advance directives when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors.
- Treatment plans that are consistent with diagnosis.
- A working diagnosis recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the Practitioner.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls or visits that include the specific time of return are noted in weeks, months or as needed, included in the next preventative care visit when appropriate.
- Notes from consultants as applicable.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow-up plan(s).
- All ancillary services report.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions and follow-up care, inpatient and outpatient care, including hospital discharge summaries, hospital history and physical and operative report.
- Labor and delivery record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped or attached to the file.
- Chart sections are easily recognized for retrieval of information.
- A release document for each Member authorizing Molina to release medial information for the facilitation of medical care.

Retrieval

- The medical record is available to the Provider at each encounter.
- The medical record is available to Molina for purposes of quality improvement.
- The medical record is available to the applicable State and/or Federal agency and the external quality review organization upon request.
- The medical record is available to the Member upon their request.

- A storage system for inactive member medical records which allows retrieval within 24 hours, is consistent with state and federal requirements, and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than 10 years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

Molina Providers shall develop and implement confidentiality procedures to guard Member protected health information, in accordance with HIPAA privacy standards and all other applicable federal and state regulations. This should include, and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable federal or state law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertains to them.
- Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information.
- Medical records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.
- Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity, and social determinants of health is protected.

Additional information on medical records is available from your local Molina Quality department. For additional information regarding HIPAA please refer to the **Compliance** section of this Provider Manual.

Advance Directives (Patient Self-Determination Act)

Molina complies with the advance directive requirements of the states in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents**.**

Advance directives are a written choice for health care. There are two (2) types of advance directives:

- **Durable Power of Attorney for Health Care** allows an agent to be appointed to carry out health care decisions.

- **Living Will** allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.

When There Is No Advance Directive: The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform adult Molina Members, 18 years old and up, of their right to make health care decisions and execute advance directives. It is important that Members are informed about advance directives.

Members who would like more information are instructed to contact the Member Services Contact Center or are directed to the Caring Connections website at Caringinfo.org/planning/advance-directives for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss advance directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

Molina network Providers and facilities are expected to communicate any objections they may have to a member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. Molina will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an advance directive. CMS regulations give Members the right to file a grievance with Molina or the state survey and certification agency if the Member is dissatisfied with Molina's handling of advance directives and/or if a Provider fails to comply with advance directive instructions.

Molina will notify the Provider via fax of an individual Member's advance directives identified through Care Coordination. Providers are instructed to document the presence of an advance directive in a prominent location of the medical record. Advance directive forms are state-specific to meet state regulations.

Molina expects that there will be documented evidence of the discussion between the Provider and the Member during routine medical record reviews.

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed include PCPs (family/general practice, internal medicine, and pediatric), OB/GYN (high-volume specialists), Oncologist (high-impact specialists), and behavioral health Providers. Providers are

required to conform to the access to care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, 7 days a week to Members.

Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted:

Medical Appointment

Appointment Type	Standard
Routine, asymptomatic	Within 30 calendar days
Routine, asymptomatic (dental)	Within 60 calendar days
Routine, symptomatic (medical & dental)	Within 14 calendar days
Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 day/week availability
Urgent Specialty Care	Within 24 hours
Maternity care, urgent	Within 24 hours
Routine, prenatal (first trimester)	Within 14 calendar days
Routine, prenatal (second trimester)	Within 7 calendar days
Routine, prenatal (third trimester)	Within 3 business days
Routine, diagnostic	Within 14 calendar days
Urgent, diagnostic	Within 48 hours
Prescription, in-person (pick-up)	Within 40 minutes
Prescription, phone/electronic submission	Within 90 minutes

Behavioral Health Appointment

Appointment Type	Standard
Life Threatening Emergency: Urgently needed services or emergency	Immediately
Non-urgent, initial assessment	Within 7 calendar days
Non-urgent, follow-up from initial assessment	Within 7 calendar days
Non-life-Threatening Crisis	Within 90 minutes
Urgent Care	Within 24 hours
Routine Care	Within 14 calendar days
Follow-up Routine Care	Within 30calendar days

Additional information on appointment access standards is available from your local Molina Quality department.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 20 minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

All Providers must have backup (on-call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, 7 days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang up and call 911 or go immediately to the nearest emergency room.

Women's Health Access

Molina allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina as providing obstetric and gynecological services. Members' access to obstetric and gynecological services is monitored to ensure Members have direct access to Participating Providers for obstetric and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.
Additional information on access to care is available under the Resources tab on the Molinahealthcare.com website or from your local Molina Quality department.

Monitoring Access for Compliance with Standards

Access to care standards is reviewed, revised as needed, and approved by the Quality Improvement and Health Equity Transformation Committee annually.

Provider network adherence to access standards is monitored via the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability and after-hours access.
2. Member grievance data – assessment of Member grievances related to access to care.
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement and Health Equity Transformation Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement and Health Equity Transformation Committee.

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record keeping practices standards. Molina continually monitors Member appeals and grievances for all office sites to determine the need for an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety, and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space

Physical Accessibility

Molina evaluates office sites to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical Appearance

The site visits include, but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety.

Adequacy of Waiting and Examining Room Space

During the site visit, Molina assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration & Confidentiality of Facilities

Facilities contracted with Molina must demonstrate overall compliance with the guidelines listed below:

- Office appearance shows that housekeeping and maintenance are performed regularly, the waiting room is well-lit, office hours are posted, and the parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible for people with disabilities with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (2) office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.

- At least one (1) CPR-certified employee is available
- Yearly Occupational Safety and Health Administration (OSHA) training (Fire, Safety, Blood-borne Pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, contracts, and evidence of hazardous waste management system in place.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers, or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A Clinical Laboratory Improvement Amendment (CLIA) waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

EPSDT Services to Enrollees Under 21 Years

Molina maintains systematic and robust monitoring mechanisms to ensure all required EPSDT Services to Enrollees under 21 years are timely according to required preventive guidelines. All Enrollees under 21 years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905(R) of the Social Security Act. Molina's Quality department is also available to perform Provider training to ensure that best practice guidelines are followed in relation to well-child services and care for acute and chronic health care needs.

Well Child/Adolescent Visits

Visits consist of age-appropriate components including but not limited to:

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height, weight and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to the Advisory Committee on Immunization Practices.
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool.

- Vision screening for preventive services. Only medically necessary services are covered. Pediatric routine vision services (one [1] eye exam per year) are accessed by Members through the March Vision network.
- Hearing screening for preventive services.
- Dental assessment and services.
- Health education (anticipatory guidance including child development, healthy lifestyles. accident and disease prevention).
- Periodic objective screening for social emotional development using a recognized, standardized tool.
- Perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit.

Diagnostic services, treatment or services Medically Necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.

Molina shall have no obligation to pay for services that are not Covered Services.

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Performance below Molina's standards may result in a corrective action plan (CAP) with a request that the Provider submits a written CAP to Molina within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

Molina maintains an active QI program. The QI program provides structure and key processes to carry out our ongoing commitment to the improvement of care and service. Molina focuses on reducing health care disparities through the QI program. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements, and strategic planning initiatives.

Health Management and Care Coordination

The Molina health management and care coordination programs provide for the identification, assessment, stratification and implementation of appropriate interventions for Members with chronic diseases.

For additional information, please refer to the Health Management and Care Coordination Management headings in the **Health Care Services** section of this Provider Manual.

Clinical Practice Guidelines

Molina adopts and disseminates clinical practice guidelines (CPG) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority.

Molina CPGs include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure in Adults
- Homelessness–Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma–Informed Primary Care

All CPGs are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health Equity Transformation

Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis, or when changes are made during the year, CPGs are distributed to Providers at MolinaHealthcare.com and the Provider Manual. Notification of the availability of the CPGs is published in the Molina Provider Newsletter.

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics and the Centers for Disease Control and Prevention (CDC), in accordance with CMS guidelines. Diagnostic preventive procedures include but are not limited to:

- Adult Preventive Services Recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on Molina's website.
- Recommendations for Preventive Pediatric Health Care (Bright Futures/American Academy of Pediatrics). Links to current recommendations are included on Molina's website.
- Recommended Adult Immunization Schedule for ages 19 Years or Older (United States). These recommendations are revised every year by the CDC. Links to current recommendations are included on Molina's website.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger (United States). These recommendations are revised every year by the CDC. Link to current recommendations is included on Molina's Website.

All preventive health guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis, or when changes are made during the year, preventive health guidelines are distributed to Providers at MolinaHealthcare.com and the Provider Manual. Notification of the availability of the preventive health guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Appropriate Services

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Molina's program and services, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

Measurement of Clinical and Service Quality

Molina monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- HEDIS®
- CAHPS®
- Behavioral Health Satisfaction Assessment

- Provider Satisfaction Survey
- Effectiveness of quality improvement Initiatives

Molina evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level.

Contracted Providers and facilities must allow Molina to use its performance data collected in accordance with the Provider Agreement with Molina. The use of performance data may include, but is not limited to, the following:

1. development of quality improvement activities;
2. public reporting to consumers;
3. preferred status designation in the network;
4. reduced Member cost sharing.

Molina's most recent results can be obtained from your local Molina Quality staff or by visiting our website at MolinaHealthcare.com.

HEDIS®

Molina utilizes NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs.

Selected HEDIS® results are provided to Federal and State regulatory agencies and accreditation organizations. The data are used to compare against established health plan performance benchmarks.

CAHPS®

CAHPS® is the tool used by Molina to summarize Member satisfaction with Providers, health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care and Getting Needed Prescription Drugs (for Medicare). The CAHPS® survey is administered annually in the spring to randomly selected Members by an NCQA-certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Behavioral Health Satisfaction Assessment

Molina obtains feedback from Members about their experience, needs, and perceptions of Members with behavioral health care. This feedback is collected at least annually to understand how our Members rate their experiences in getting treatment, communicating with their clinicians, receiving treatment and information from the plan, among other areas.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on Member experience with health care providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

Molina monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices." The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, Molina also compiles grievances and appeals data, as well as requests for out-of-network services to determine opportunities for service improvements.

What Can Providers Do?

- Ensure patients are up to date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology;
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed;
- Check that staff are properly coding all services provided; and,
- Be sure patients understand what *they* need to do.

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Availity Essentials portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS® survey Star Ratings measures, contact your local Molina Quality department.

18. RISK ADJUSTMENT MANAGEMENT PROGRAM

What is Risk Adjustment?

CMS defines risk adjustment as a process that helps accurately measure the health status of a plan's Membership based on medical conditions and demographic information.
This process helps ensure health plans receive accurate payment for services provided to Molina Members and prepares for resources that may be needed in the future.

Why is Risk Adjustment Important?

Molina relies on our Provider Network to care for our Members based on their health care needs. Risk Adjustment considers numerous clinical data elements of a Member's health profile to determine documentation gaps from past visits and identify opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Allows Molina to focus on quality and efficiency.
- Enables Molina to recognize and address current and potential health conditions.
- Identifies Members for Case Coordination referral.
- Ensures accurate payment for the acuity levels of Molina Members.
- Risk Adjustment allows Molina to have the resources to deliver the highest quality of care to Molina Members.

Interoperability

The Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format at encounter close for Molina Members by using one of the automated methods available and supported by Provider's electronic medical records (EMR), including, but not limited to, Epic Payer Platform, Direct Protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource).

The CDA or CCD document should include signed clinical notes or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

The Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

The Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the HIPAA-compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If the Provider does not have Direct Access, the Provider will work with its EMR vendor to set up a Direct Messaging Account, which also supports the CMS Requirement of having the Provider's Digital Contact Information added in NPPES.
- If the Provider's EMR does not support the Direct Protocol, the Provider will work with Molina's established interoperability partner to get an account established.

Your Role as a Provider

As a Provider, complete and accurate documentation in a medical record is critical to a Member's quality of care. We encourage Providers to record all diagnoses to the highest specificity. This will ensure Molina receives adequate resources to provide quality programs to you and our Members.

For a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina and reviewed with the Member.
- Be compliant with the CMS National Correct Coding Initiative (NCCI).
- Use the correct ICD-10 code by documenting the condition to the highest level of specificity.
- Only submit codes for diagnoses confirmed during a Provider visit with a member. The visit may be face-to-face or telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes.
- Be clear and concise.
- Contain the Member's name and date of service.
- Have the physician's signature and credentials.

Contact Information

For questions about Molina's Risk Adjustment programs, please contact your Molina Provider Relations representative.

19. TRANSITION OF CARE PROGRAMS

Molina has goals, processes, and systems in place to ensure smooth transitions between Member's setting of care and level of care. This includes transitions to and from inpatient settings (i.e., Nursing Facility to Home).
All care coordinators are trained on the transitions of care approach that Molina follows for transitions between care settings. The care coordinators can use tablet technology to facilitate on-site, in-person, and home-based assessments that are housed in an electronic health management platform.

Children in State Custody (CISC)

All non-Native American CISC Members will be automatically enrolled with the HCA designated CISC Managed Care Organization (MCO), Presbyterian Health Plan (PHP). PHP will be the only MCO managing care for non-Native American CISC. The enrollment effective date will be the first day of the month when the child is taken into state custody. Once the member is enrolled and in state custody, they will not be able to select a different MCO. In addition, when the Member has left state custody, they will be disenrolled effective the last day of the month. Molina will ensure Covered Services are available for Native American CISC Members. The enrollment of Native American CISC recipients is voluntary. They may enroll with any MCO or receive services through HCA's fee-for-service Medicaid program.
Molina will work with the Tribal custody team within three (3) business days of notification of a member in Tribal custody and will assign a care coordinator to help the member/member's team. Working with the caregiver, legal representative and legal custodian during this time is very important. Members who are 14 years or older can participate in their care plan and designate their authorized representative. Molina will request all screenings completed by the Tribal custody team and providers to begin the Health Risk Assessment and Comprehensive Needs Assessment.
For all transitions of care of CISC or children in Tribal custody, Molina will work with Tribal protective services in the development of the transition of care plan. Molina will ensure the continuity of care for CISC or children in Tribal custody, by allowing these Members to continue receiving services from Non-contract providers, honor existing service authorizations and reimbursing non-contract providers.

Claims for LTSS Services

Providers are required to bill Molina for all LTSS waiver services by mail, electronically, using EDI submission, or through the Availity portal. After registering on Availity a Provider will be able to check eligibility, claim status and create/submit claims to Molina. To register please visit Availity.
For information on how to submit a claim via the Availity portal contact the Molina Provider Contact Center at (855) 322-4078.

Billing Molina

Atypical Providers

Atypical Providers are service Providers that do not meet the definition of health care Provider. Examples include taxi services, home and vehicle modifications, insect control, habilitation, and respite services, etc. Although they are not required to register for an NPI, these Providers perform services that are reimbursed by Molina Healthcare of New Mexico.

Atypical Providers are required to use their Federal Employee identification Number (FEIN/SSN) given to them by the state to take the place of the NPI.

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